

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12089

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>COCKEYSVILLE</u> LENGTH OF STAY (in this place) <u>2 1/2 years</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MASONIC HOME</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>1</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u> 3V01-4 STREET ADDRESS (If rural give location) <u>3033 ARUNAH AVE</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>MAIZEE B.</u> (Middle) <u>ANTHONY</u> (Last) _____		4. DATE OF DEATH (Month) <u>12</u> (Day) <u>17</u> (Year) <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>NOV. 24, 1874</u>
9. AGE last birthday <u>82</u> yrs.		10. IF UNDER 1 YEAR (Months) _____ (Days) _____ (Hours) _____ (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM D. BRENGLE</u>		14. MOTHER'S MAIDEN NAME <u>BETTIE MARTIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>218-22-3517</u>	
17. INFORMANT & ADDRESS <u>Frank L. Smith Jr. Cockeysville, Md.</u>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.1</u> IMMEDIATE CAUSE (A) <u>Arterio Sclerotic Cardio Vascular disease</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) _____ (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) _____	
21c. WHERE DID INJURY OCCUR? (City or town) _____ (County) _____ (State) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>3-27-53</u> , 19_____, to <u>12-14-56</u> , 19_____, that I last saw the deceased alive on <u>12-14</u> , 19 <u>56</u> , and that death occurred at <u>5:10 A.M.</u> , from the causes and on the date stated above. SIGNATURE <u>Walter J. Keen</u> M.D. <u>Cockeysville, Md.</u> ADDRESS (Street, city, town, state) <u>12/17/56</u> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-19-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
24. REC'D BY REGISTRAR <u>Frank Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>	
DATE <u>12/19/56</u>			

BUREAU A. 2

DEC 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12119

CERTIFICATE OF DEATH

12090

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>1412 Patapsco Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>HOWARD</u> Middle <u>K</u> Last <u>ARNOLD</u>				4. DATE OF DEATH Month <u>December</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>May 5, 1894</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contracting Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>William F. Arnold</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Baldwin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>218-01-1420</u>		17. INFORMANT <u>Clinical Rec., Vet. Adm. Hospital, Fort Howard, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASS OF HEMORRHAGE CEREBELLUM HEMISPHERE</u> DUE TO (b) _____ DUE TO (c) _____</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>VA</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 28, 1956</u> , to <u>December 4, 1956</u> , and that death occurred at <u>10:15 AM</u> from the causes and on the date stated above. <div style="display: flex; justify-content: space-between;"> <div> <p>ACTUAL SIGNATURE <u>Donald D. Mark</u> PHYSICIAN'S NAME (Type) <u>DONALD D. MARK, M.D.</u></p> </div> <div> <p>ADDRESS (Street, city or town, state) <u>VAH FT. HOWARD, MD</u> DATE SIGNED <u>12/4/56</u></p> </div> </div>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-7-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight Inc., 6009 Harford Rd.</u>				24a. REC'D BY REGISTRAR <u>12/4/56</u>		24b. REGISTRAR'S SIGNATURE <u>L. L. Fisher</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12091

12120

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOWLEYS QUARTERS</u>		c. LENGTH OF STAY IN 1b <u>BOWLEYS QUARTERS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOX 539 ROUTE 15 BALTO. 26</u>		d. STREET ADDRESS <u>BOX 539 ROUTE 15 BALTO. 26</u>	
3. NAME OF DECEASED (Type or print) <u>WALTER</u> First Middle Last <u>BALDWIN</u>		4. DATE OF DEATH <u>12/4/1956</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 6 - 1892</u>
9. AGE (In years lost birthday) <u>64</u> yrs.		10. IF UNDER 24 HRS. Magths Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>	
11c. BIRTHPLACE (State or foreign country) <u>WISCONSIN</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>PHILANDER BALDWIN</u>		14. MOTHER'S MAIDEN NAME <u>ESTHER ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MABEL BALDWIN</u>		Address <u>SAME AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u> <u>197X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 7</u> , 1956, to <u>Dec 5</u> , 1956, that I last saw the deceased alive on <u>Dec 5</u> , 1956, and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James F. White</u>		ADDRESS (Street, city or town, state) <u>M.D. 422 Eastern Ave, Balt 21, Md 1496</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/7/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OLIVE LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connelly</u>		ADDRESS <u>Essex - Balto. 21</u>	
24a. REC'D BY REGISTRAR <u>DEC 7 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farley</u>	

12621

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. PLACE OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF CORONER		13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS		15. SIGNATURE OF REGISTRAR	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESS		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF CORONER	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF WITNESS		23. SIGNATURE OF REGISTRAR		24. SIGNATURE OF PHYSICIAN		25. SIGNATURE OF CORONER	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF WITNESS		28. SIGNATURE OF REGISTRAR		29. SIGNATURE OF PHYSICIAN		30. SIGNATURE OF CORONER	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF WITNESS		33. SIGNATURE OF REGISTRAR		34. SIGNATURE OF PHYSICIAN		35. SIGNATURE OF CORONER	
36. SIGNATURE OF DECEASED		37. SIGNATURE OF WITNESS		38. SIGNATURE OF REGISTRAR		39. SIGNATURE OF PHYSICIAN		40. SIGNATURE OF CORONER	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF WITNESS		43. SIGNATURE OF REGISTRAR		44. SIGNATURE OF PHYSICIAN		45. SIGNATURE OF CORONER	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF WITNESS		48. SIGNATURE OF REGISTRAR		49. SIGNATURE OF PHYSICIAN		50. SIGNATURE OF CORONER	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF WITNESS		53. SIGNATURE OF REGISTRAR		54. SIGNATURE OF PHYSICIAN		55. SIGNATURE OF CORONER	
56. SIGNATURE OF DECEASED		57. SIGNATURE OF WITNESS		58. SIGNATURE OF REGISTRAR		59. SIGNATURE OF PHYSICIAN		60. SIGNATURE OF CORONER	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF WITNESS		63. SIGNATURE OF REGISTRAR		64. SIGNATURE OF PHYSICIAN		65. SIGNATURE OF CORONER	
66. SIGNATURE OF DECEASED		67. SIGNATURE OF WITNESS		68. SIGNATURE OF REGISTRAR		69. SIGNATURE OF PHYSICIAN		70. SIGNATURE OF CORONER	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF WITNESS		73. SIGNATURE OF REGISTRAR		74. SIGNATURE OF PHYSICIAN		75. SIGNATURE OF CORONER	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF WITNESS		78. SIGNATURE OF REGISTRAR		79. SIGNATURE OF PHYSICIAN		80. SIGNATURE OF CORONER	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF WITNESS		83. SIGNATURE OF REGISTRAR		84. SIGNATURE OF PHYSICIAN		85. SIGNATURE OF CORONER	
86. SIGNATURE OF DECEASED		87. SIGNATURE OF WITNESS		88. SIGNATURE OF REGISTRAR		89. SIGNATURE OF PHYSICIAN		90. SIGNATURE OF CORONER	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF WITNESS		93. SIGNATURE OF REGISTRAR		94. SIGNATURE OF PHYSICIAN		95. SIGNATURE OF CORONER	
96. SIGNATURE OF DECEASED		97. SIGNATURE OF WITNESS		98. SIGNATURE OF REGISTRAR		99. SIGNATURE OF PHYSICIAN		100. SIGNATURE OF CORONER	

BUREAU V. S.

DEC 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12121

CERTIFICATE OF DEATH

12092

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN lb 82 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS Route #1, Annapolis			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ERIC Middle L. Last BARK				4. DATE OF DEATH Month December Day 31 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/5/1900	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Personal Relations				10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co. Sweden			
11. BIRTHPLACE (State or foreign country) Sweden				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Gustave Bark				14. MOTHER'S MAIDEN NAME Signe Lingrand			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II				16. SOCIAL SECURITY NO. 025-12-2827		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRRHOSIS OF LIVER DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Carcinoma of stomach. 2. Arteriosclerotic heart disease 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 10, 1956 , to December 31, 1956 , and that death occurred at 11:35 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 12/31/56 ACTUAL SIGNATURE C. J. Papastrat M.D. M.D. _____ PHYSICIAN'S NAME (Type) C. J. PAPASTRAT, M.D. VAH, FORT HOWARD, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1-1-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. ADDRESS Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14, Md.							
24a. REC'D BY REGISTRAR DATE 2 1957				24b. REGISTRAR'S SIGNATURE James L. Fisher			

Shipped to W. W. Chambers Co. 1400 Chapin St. N.W., Washington D. C.

CERTIFICATE OF DEATH

PLACE OF DEATH		MARRIAGE	
At Home		None	
Date of Death		Date of Marriage	
Jan 3 1957		None	
Time of Death		Time of Marriage	
10:00 AM		None	
Cause of Death		Cause of Marriage	
Heart Disease		None	
Nature of Injury		Nature of Injury	
None		None	
Place of Birth		Place of Birth	
Baltimore		Baltimore	
Age		Age	
65		65	
Sex		Sex	
Male		Male	
Race		Race	
White		White	
Occupation		Occupation	
None		None	
Signature of Physician		Signature of Physician	
None		None	
Signature of Registrar		Signature of Registrar	
None		None	
Date of Registration		Date of Registration	
Jan 3 1957		Jan 3 1957	
Place of Registration		Place of Registration	
Baltimore		Baltimore	
Signature of Registrar		Signature of Registrar	
None		None	

RECEIVED

JAN 3 1957

BUREAU V. 4

1-4-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12093

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore County</i> 9647 Alda Drive		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Balto. Co.</i>		c. LENGTH OF STAY IN 1b <i>Life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Balto. Co.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>9647 Alda Drive</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Earl N. Berry</i> Middle Last		4. DATE OF DEATH Month <i>12</i> Day <i>27</i> Year <i>1956</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 25, 1906</i>	9. AGE (In years last birthday) <i>50</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Sun Cab Co.</i>		11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>	
13. FATHER'S NAME <i>William H. Berry</i>		14. MOTHER'S MAIDEN NAME <i>Hatfield</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Irene E. Berry</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic carcinoma of the testis</i> <i>178X</i> DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Balto. Co.</i>	(County) (State)	
21. I certify that I attended the deceased from <i>Sept. 1954</i> , to <i>Dec. 1956</i> , that I last saw the deceased alive on <i>Dec. 27, 1956</i> , and that death occurred at <i>7:15 P.M.</i> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>William H. Berry</i>		ADDRESS (Street, city or town, state) <i>800 Harford St., Balto. Md.</i>		DATE SIGNED <i>12-28-56</i>	
PHYSICIAN'S NAME (Type) <i>S. Elliott Harris M.D.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/31/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood</i>	22d. LOCATION (City, town, or county) <i>Balto. Co.</i>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>12/31/56</i>	24b. REGISTRAR'S SIGNATURE <i>W. H. Harrison</i>

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF NEXT OF KIN		19. SIGNATURE OF CLERGYMAN		20. SIGNATURE OF BURIAL OFFICER		21. SIGNATURE OF FUNERAL HOME		22. SIGNATURE OF CEMETERY		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF SUPERVISOR	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF NEXT OF KIN		27. SIGNATURE OF CLERGYMAN		28. SIGNATURE OF BURIAL OFFICER		29. SIGNATURE OF FUNERAL HOME		30. SIGNATURE OF CEMETERY		31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF SUPERVISOR	
33. SIGNATURE OF DECEASED		34. SIGNATURE OF NEXT OF KIN		35. SIGNATURE OF CLERGYMAN		36. SIGNATURE OF BURIAL OFFICER		37. SIGNATURE OF FUNERAL HOME		38. SIGNATURE OF CEMETERY		39. SIGNATURE OF INTERVIEWER		40. SIGNATURE OF SUPERVISOR	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF NEXT OF KIN		43. SIGNATURE OF CLERGYMAN		44. SIGNATURE OF BURIAL OFFICER		45. SIGNATURE OF FUNERAL HOME		46. SIGNATURE OF CEMETERY		47. SIGNATURE OF INTERVIEWER		48. SIGNATURE OF SUPERVISOR	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF NEXT OF KIN		51. SIGNATURE OF CLERGYMAN		52. SIGNATURE OF BURIAL OFFICER		53. SIGNATURE OF FUNERAL HOME		54. SIGNATURE OF CEMETERY		55. SIGNATURE OF INTERVIEWER		56. SIGNATURE OF SUPERVISOR	
57. SIGNATURE OF DECEASED		58. SIGNATURE OF NEXT OF KIN		59. SIGNATURE OF CLERGYMAN		60. SIGNATURE OF BURIAL OFFICER		61. SIGNATURE OF FUNERAL HOME		62. SIGNATURE OF CEMETERY		63. SIGNATURE OF INTERVIEWER		64. SIGNATURE OF SUPERVISOR	
65. SIGNATURE OF DECEASED		66. SIGNATURE OF NEXT OF KIN		67. SIGNATURE OF CLERGYMAN		68. SIGNATURE OF BURIAL OFFICER		69. SIGNATURE OF FUNERAL HOME		70. SIGNATURE OF CEMETERY		71. SIGNATURE OF INTERVIEWER		72. SIGNATURE OF SUPERVISOR	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF NEXT OF KIN		75. SIGNATURE OF CLERGYMAN		76. SIGNATURE OF BURIAL OFFICER		77. SIGNATURE OF FUNERAL HOME		78. SIGNATURE OF CEMETERY		79. SIGNATURE OF INTERVIEWER		80. SIGNATURE OF SUPERVISOR	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF NEXT OF KIN		83. SIGNATURE OF CLERGYMAN		84. SIGNATURE OF BURIAL OFFICER		85. SIGNATURE OF FUNERAL HOME		86. SIGNATURE OF CEMETERY		87. SIGNATURE OF INTERVIEWER		88. SIGNATURE OF SUPERVISOR	
89. SIGNATURE OF DECEASED		90. SIGNATURE OF NEXT OF KIN		91. SIGNATURE OF CLERGYMAN		92. SIGNATURE OF BURIAL OFFICER		93. SIGNATURE OF FUNERAL HOME		94. SIGNATURE OF CEMETERY		95. SIGNATURE OF INTERVIEWER		96. SIGNATURE OF SUPERVISOR	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF NEXT OF KIN		99. SIGNATURE OF CLERGYMAN		100. SIGNATURE OF BURIAL OFFICER		101. SIGNATURE OF FUNERAL HOME		102. SIGNATURE OF CEMETERY		103. SIGNATURE OF INTERVIEWER		104. SIGNATURE OF SUPERVISOR	
105. SIGNATURE OF DECEASED		106. SIGNATURE OF NEXT OF KIN		107. SIGNATURE OF CLERGYMAN		108. SIGNATURE OF BURIAL OFFICER		109. SIGNATURE OF FUNERAL HOME		110. SIGNATURE OF CEMETERY		111. SIGNATURE OF INTERVIEWER		112. SIGNATURE OF SUPERVISOR	
113. SIGNATURE OF DECEASED		114. SIGNATURE OF NEXT OF KIN		115. SIGNATURE OF CLERGYMAN		116. SIGNATURE OF BURIAL OFFICER		117. SIGNATURE OF FUNERAL HOME		118. SIGNATURE OF CEMETERY		119. SIGNATURE OF INTERVIEWER		120. SIGNATURE OF SUPERVISOR	
121. SIGNATURE OF DECEASED		122. SIGNATURE OF NEXT OF KIN		123. SIGNATURE OF CLERGYMAN		124. SIGNATURE OF BURIAL OFFICER		125. SIGNATURE OF FUNERAL HOME		126. SIGNATURE OF CEMETERY		127. SIGNATURE OF INTERVIEWER		128. SIGNATURE OF SUPERVISOR	
129. SIGNATURE OF DECEASED		130. SIGNATURE OF NEXT OF KIN		131. SIGNATURE OF CLERGYMAN		132. SIGNATURE OF BURIAL OFFICER		133. SIGNATURE OF FUNERAL HOME		134. SIGNATURE OF CEMETERY		135. SIGNATURE OF INTERVIEWER		136. SIGNATURE OF SUPERVISOR	
137. SIGNATURE OF DECEASED		138. SIGNATURE OF NEXT OF KIN		139. SIGNATURE OF CLERGYMAN		140. SIGNATURE OF BURIAL OFFICER		141. SIGNATURE OF FUNERAL HOME		142. SIGNATURE OF CEMETERY		143. SIGNATURE OF INTERVIEWER		144. SIGNATURE OF SUPERVISOR	
145. SIGNATURE OF DECEASED		146. SIGNATURE OF NEXT OF KIN		147. SIGNATURE OF CLERGYMAN		148. SIGNATURE OF BURIAL OFFICER		149. SIGNATURE OF FUNERAL HOME		150. SIGNATURE OF CEMETERY		151. SIGNATURE OF INTERVIEWER		152. SIGNATURE OF SUPERVISOR	
153. SIGNATURE OF DECEASED		154. SIGNATURE OF NEXT OF KIN		155. SIGNATURE OF CLERGYMAN		156. SIGNATURE OF BURIAL OFFICER		157. SIGNATURE OF FUNERAL HOME		158. SIGNATURE OF CEMETERY		159. SIGNATURE OF INTERVIEWER		160. SIGNATURE OF SUPERVISOR	
161. SIGNATURE OF DECEASED		162. SIGNATURE OF NEXT OF KIN		163. SIGNATURE OF CLERGYMAN		164. SIGNATURE OF BURIAL OFFICER		165. SIGNATURE OF FUNERAL HOME		166. SIGNATURE OF CEMETERY		167. SIGNATURE OF INTERVIEWER		168. SIGNATURE OF SUPERVISOR	
169. SIGNATURE OF DECEASED		170. SIGNATURE OF NEXT OF KIN		171. SIGNATURE OF CLERGYMAN		172. SIGNATURE OF BURIAL OFFICER		173. SIGNATURE OF FUNERAL HOME		174. SIGNATURE OF CEMETERY		175. SIGNATURE OF INTERVIEWER		176. SIGNATURE OF SUPERVISOR	
177. SIGNATURE OF DECEASED		178. SIGNATURE OF NEXT OF KIN		179. SIGNATURE OF CLERGYMAN		180. SIGNATURE OF BURIAL OFFICER		181. SIGNATURE OF FUNERAL HOME		182. SIGNATURE OF CEMETERY		183. SIGNATURE OF INTERVIEWER		184. SIGNATURE OF SUPERVISOR	
185. SIGNATURE OF DECEASED		186. SIGNATURE OF NEXT OF KIN		187. SIGNATURE OF CLERGYMAN		188. SIGNATURE OF BURIAL OFFICER		189. SIGNATURE OF FUNERAL HOME		190. SIGNATURE OF CEMETERY		191. SIGNATURE OF INTERVIEWER		192. SIGNATURE OF SUPERVISOR	
193. SIGNATURE OF DECEASED		194. SIGNATURE OF NEXT OF KIN		195. SIGNATURE OF CLERGYMAN		196. SIGNATURE OF BURIAL OFFICER		197. SIGNATURE OF FUNERAL HOME		198. SIGNATURE OF CEMETERY		199. SIGNATURE OF INTERVIEWER		200. SIGNATURE OF SUPERVISOR	

BUREAU V. S.

AN 2 1937

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12094

12123

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>932 Coleridge Rd.</u>		d. STREET ADDRESS <u>932 Coleridge Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>A.</u> Last <u>Beyerling</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>31</u> Year <u>19 56</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 12, 1893</u>
9. AGE (In years last birthday) yrs. <u>63</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>O.H.</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Holt</u>		14. MOTHER'S MAIDEN NAME <u>Amelia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Paul W. Beyerling, 932 Coleridge Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-Vascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 2</u> , 19 <u>47</u> , to <u>Dec 31</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 31</u> , 19 <u>56</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>CJ Mendelis</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>651 N Bentalow St</u> <u>12/31/56</u>	
PHYSICIAN'S NAME (Type) <u>CJ Mendelis</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 2/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Western Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witzler</u>		ADDRESS <u>4101 Edmondson Ave</u>	
24a. REC'D BY REGISTRAR <u>Jan 3 57</u>		24b. REGISTRAR'S SIGNATURE <u>R. W. ...</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	

CERTIFICATE OF DEATH

Reg. Dist. No.

12124

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Balt.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR		TOWN	
55 TOWN <u>Towson</u>		8 yrs.		TOWN <u>Baltimore</u>		3Y01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
13 Sheppard Enoch Pratt Hosp				RIVERIA APTS LINDEN AVE LAKE DRIVE			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH:		(Month) (Day) (Year)	
(Type or Print)		HANNAH JOFFE BLOOM		DATE OF DEATH: 12 2 1956			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Fem.	white	WIDOW	1-20-1885	71 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Housewife		—		Maryland		U.S.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
max Joffe				Zelda Joffe			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
No				Mrs. Lena Cohen - Newman, 1424-26 N. York Ave.			

18. MEDICAL CERTIFICATION			Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
170X Immediate cause (a) <u>Bronchopneumonia</u>			10 days.
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Carcinoma of breast</u>			5 1/2 yrs.
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
- Senile psychosis			
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
—	—	—	—	—
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
—	—	—		

22. I hereby certify that I attended the deceased from 7-22-1948 to Dec 2, 1956 that I last saw the deceased alive on Dec 1, 1956, and that death occurred at 8:40 AM from the causes and on the date stated above.

SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED	
M. Elgin, M.D.		Sheppard Pratt Hosp.		Towson, Md.		12/2/56	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
Burial	Dec 4/56	Belmont Gardens		Baltimore Md			
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		ADDRESS			
Dec 4, 1956	A. W. Hedrick	Hedrick & Son, 1124-26 N. York Ave.					

MARGIN RESERVED FOR FILING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ACQUAINTANCE

EXILE - 1

1971

1972

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12023

12125 CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) g. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pandallstown Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pandallstown Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Powells Run Road</u>		d. STREET ADDRESS <u>Powells Run Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Shelby</u> Middle <u>Jean</u> Last <u>Bofst</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25, 56</u>
9. AGE (In years lost birthday) yrs. <u>28</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Milton S. Bofst</u>		14. MOTHER'S MAIDEN NAME <u>Edith Vera Byers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Edith Vera Bofst</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity (about 5 months)</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Not known</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/28/1956</u> , to <u>12/28/1956</u> , that I last saw the deceased alive on <u>12/28/1956</u> , and that death occurred at <u>9:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. E. Martin</u>		M.D. <u>Pandallstown Md</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>9/29/56</u>	
PHYSICIAN'S NAME (Type) <u>Wm. E. Martin</u>		<u>PANDALLSTOWN MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-29-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		22d. LOCATION (City, town, or county) (State) <u>Springville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Wright</u>		ADDRESS <u>Springville, Md.</u>	
24a. REC'D BY REGISTRAR <u>Wm. E. Martin</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. E. Martin</u>	
DATE <u>12/29/56</u>			

1000334XVI

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MARYLAND

RECEIVED

1957

MORRIS V. B.

THE DECEASED WAS FIRST FOUND DEAD AT THE FOLLOWING PLACE:

THE DECEASED WAS FOUND BY THE FOLLOWING PERSON:

THE DECEASED WAS FOUND AT THE FOLLOWING PLACE:

THE DECEASED WAS FOUND BY THE FOLLOWING PERSON:

THE DECEASED WAS FOUND AT THE FOLLOWING PLACE:

THE DECEASED WAS FOUND BY THE FOLLOWING PERSON:

THE DECEASED WAS FOUND AT THE FOLLOWING PLACE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Film G208 12-13-56 et

CERTIFICATE OF DEATH

12096

Reg. Dist. No.

12110

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6779 WOODLEY RD.		d. STREET ADDRESS 6779 WOODLEY RD.	
3. NAME OF DECEASED (Type or print) First GEORGE Middle L. Last BORING		4. DATE OF DEATH Month DEC. Day 4 Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 15, 1969
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIRE INSP.		10b. KIND OF BUSINESS OR INDUSTRY BETHLEHEM STEEL	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT STEPHEN WHITE		Address 6779 WOODLEY RD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Cardio-Vas Dis. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Terminal Hypertensive Pneumonia			
INTERVAL BETWEEN ONSET AND DEATH 15 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July - , 19 56 to Dec. 4 , 19 56 , that I last saw the deceased alive on Dec. 2 , 19 56 , and that death occurred at 8:25 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M.B. Davis		ADDRESS (Street, city or town, state) 6800 MORNINGSTAR AVE - 12/4/56	
PHYSICIAN'S NAME (Type) M.B. DAVIS M.D.		DATE SIGNED Dundalk - 22 - MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/6/56	
22c. NAME OF CEMETERY OR CREMATORY MEADOW RIDGE		22d. LOCATION (City, town, or county) (State) DORSEY MD.	
23. FUNERAL DIRECTOR'S SIGNATURE ULLRICH FUNERAL HOME		ADDRESS BALTO. MD.	
24a. REC'D BY REGISTRAR DEC 7 1956		24b. REGISTRAR'S SIGNATURE M. Kelly	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint handwritten name]</p>		<p>2. SEX [Faint handwritten sex]</p>	
<p>3. AGE [Faint handwritten age]</p>		<p>4. DATE OF BIRTH [Faint handwritten date]</p>	
<p>5. PLACE OF BIRTH [Faint handwritten place]</p>		<p>6. OCCUPATION [Faint handwritten occupation]</p>	
<p>7. MARITAL STATUS [Faint handwritten status]</p>		<p>8. CAUSE OF DEATH [Faint handwritten cause]</p>	
<p>9. MEDICAL HISTORY [Faint handwritten history]</p>		<p>10. DATE OF DEATH [Faint handwritten date]</p>	
<p>11. PLACE OF DEATH [Faint handwritten place]</p>		<p>12. SIGNATURE OF PHYSICIAN [Faint handwritten signature]</p>	
<p>13. SIGNATURE OF REGISTRAR [Faint handwritten signature]</p>		<p>14. OFFICIAL USE [Faint handwritten notes]</p>	

BUREAU V. S.

DEC 10 1956

RECEIVED

12126 CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wards Chapel				c. LENGTH OF STAY IN 1b 75 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wards Chapel Road				d. STREET ADDRESS Wards Chapel Road			
3. NAME OF DECEASED (Type or print) First John Middle Henry Last Brady				4. DATE OF DEATH Month December Day 8 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 23, 1875	
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 8 Days 1 Hours 1 Min. 0		11. BIRTHPLACE (State or foreign country) Pikesville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Pikesville, Md.	
13. FATHER'S NAME John T. Brady				14. MOTHER'S MAIDEN NAME Elizabeth McCanroe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Elsie May Brady, Wards Chapel Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 12 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Harrisonville, Md.				20g. (County) Harrisonville, Md.			
20h. (State) Md.				20i. (City or town) Harrisonville, Md.			
21. I certify that I attended the deceased from 1954 , 1956 , to Dec. 8 , 1956 , that I last saw the deceased alive on Dec. 6 , 1956 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. E. Martin				ADDRESS (Street, city or town, state) Randallstown Md			
PHYSICIAN'S NAME (Type) Wm. E. Martin				DATE SIGNED 12/9/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/11/56		22c. NAME OF CEMETERY OR CREMATORY Holy Family		22d. LOCATION (City, town, or county) (State) Harrisonville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank A. Quirell-Pikesville, Md.				24a. REC'D BY REGISTRAR 12/9/56		24b. REGISTRAR'S SIGNATURE Wm. E. Martin	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Form 10-56

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. AGE [REDACTED]</p>	
<p>4. DATE OF DEATH [REDACTED]</p>		<p>5. TIME OF DEATH [REDACTED]</p>		<p>6. PLACE OF DEATH [REDACTED]</p>	
<p>7. CAUSE OF DEATH [REDACTED]</p>		<p>8. MANNER OF DEATH [REDACTED]</p>		<p>9. PLACE OF BIRTH [REDACTED]</p>	
<p>10. OCCUPATION [REDACTED]</p>		<p>11. MARITAL STATUS [REDACTED]</p>		<p>12. EDUCATION [REDACTED]</p>	
<p>13. PREVIOUS ILLNESS [REDACTED]</p>		<p>14. MEDICAL HISTORY [REDACTED]</p>		<p>15. SURVIVAL OF OTHERS [REDACTED]</p>	
<p>16. SIGNATURE OF DECEASED [REDACTED]</p>		<p>17. SIGNATURE OF WITNESS [REDACTED]</p>		<p>18. SIGNATURE OF PHYSICIAN [REDACTED]</p>	
<p>19. SIGNATURE OF CORONER [REDACTED]</p>		<p>20. SIGNATURE OF JURY [REDACTED]</p>		<p>21. SIGNATURE OF JUDGE [REDACTED]</p>	

BUREAU V. 2

DEC 11 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12127 CERTIFICATE OF DEATH

12098

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon				c. LENGTH OF STAY IN 1b 1 Mon.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Butler Road				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3401.4			
				d. STREET ADDRESS 1720 Hall Ave.			
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Brandenburg				4. DATE OF DEATH Month Dec. Day 26 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan, 1, 1886	
				9. AGE (In years less birth day) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Nurse				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME George F. Reter				14. MOTHER'S MAIDEN NAME Catherine Lins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		(If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-28-5784		17. INFORMANT Catherine Wetzel Baltimore, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Angina Pectoris DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none						INTERVAL BETWEEN ONSET AND DEATH 4 hrs. 6 mo.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. none p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		
			20f. (City or town) Reisterstown			(County) (State)	
21. I certify that I attended the deceased from Dec. 13, 1956 to Dec. 26, 1956 , that I last saw the deceased alive on Dec. 26, 1956 , and that death occurred at 6 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE D.D. Caples				DATE SIGNED 12-27-56			
PHYSICIAN'S NAME (Type) D.D. CAPLES				ADDRESS (Street, city or town, state) Reisterstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 29, 1956		22c. NAME OF CEMETERY OR CREMATORY Brandenburg Cemetery		22d. LOCATION (City, town, or county) (State) Carroll Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons Reisterstown, Md.				24a. REC'D BY REGISTRAR DATE 12-29-56		24b. REGISTRAR'S SIGNATURE Mary B Eline	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

<p>1. Name of deceased: George F. Foster</p>		<p>2. Sex: Male</p>	
<p>3. Date of birth: Dec. 28, 1890</p>		<p>4. Place of birth: Baltimore, Md.</p>	
<p>5. Date of death: Dec. 28, 1957</p>		<p>6. Place of death: Baltimore, Md.</p>	
<p>7. Cause of death: Heart disease</p>		<p>8. Manner of death: Natural</p>	
<p>9. Name of physician: Dr. J. H. Smith</p>		<p>10. Name of funeral home: George F. Foster</p>	
<p>11. Name of next of kin: Charles F. Foster</p>		<p>12. Address of next of kin: 1234 Main St., Baltimore, Md.</p>	
<p>13. Name of informant: George F. Foster</p>		<p>14. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>15. Name of registrar: John A. Smith</p>		<p>16. Address of registrar: 1234 Main St., Baltimore, Md.</p>	
<p>17. Name of witness: John A. Smith</p>		<p>18. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>19. Name of witness: John A. Smith</p>		<p>20. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>21. Name of witness: John A. Smith</p>		<p>22. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>23. Name of witness: John A. Smith</p>		<p>24. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>25. Name of witness: John A. Smith</p>		<p>26. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>27. Name of witness: John A. Smith</p>		<p>28. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>29. Name of witness: John A. Smith</p>		<p>30. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>31. Name of witness: John A. Smith</p>		<p>32. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>33. Name of witness: John A. Smith</p>		<p>34. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>35. Name of witness: John A. Smith</p>		<p>36. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>37. Name of witness: John A. Smith</p>		<p>38. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>39. Name of witness: John A. Smith</p>		<p>40. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>41. Name of witness: John A. Smith</p>		<p>42. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>43. Name of witness: John A. Smith</p>		<p>44. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>45. Name of witness: John A. Smith</p>		<p>46. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>47. Name of witness: John A. Smith</p>		<p>48. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>49. Name of witness: John A. Smith</p>		<p>50. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>51. Name of witness: John A. Smith</p>		<p>52. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>53. Name of witness: John A. Smith</p>		<p>54. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>55. Name of witness: John A. Smith</p>		<p>56. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>57. Name of witness: John A. Smith</p>		<p>58. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>59. Name of witness: John A. Smith</p>		<p>60. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>61. Name of witness: John A. Smith</p>		<p>62. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>63. Name of witness: John A. Smith</p>		<p>64. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>65. Name of witness: John A. Smith</p>		<p>66. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>67. Name of witness: John A. Smith</p>		<p>68. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>69. Name of witness: John A. Smith</p>		<p>70. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>71. Name of witness: John A. Smith</p>		<p>72. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>73. Name of witness: John A. Smith</p>		<p>74. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>75. Name of witness: John A. Smith</p>		<p>76. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>77. Name of witness: John A. Smith</p>		<p>78. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>79. Name of witness: John A. Smith</p>		<p>80. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>81. Name of witness: John A. Smith</p>		<p>82. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>83. Name of witness: John A. Smith</p>		<p>84. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>85. Name of witness: John A. Smith</p>		<p>86. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>87. Name of witness: John A. Smith</p>		<p>88. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>89. Name of witness: John A. Smith</p>		<p>90. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>91. Name of witness: John A. Smith</p>		<p>92. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>93. Name of witness: John A. Smith</p>		<p>94. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>95. Name of witness: John A. Smith</p>		<p>96. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>97. Name of witness: John A. Smith</p>		<p>98. Address of witness: 1234 Main St., Baltimore, Md.</p>	
<p>99. Name of witness: John A. Smith</p>		<p>100. Address of witness: 1234 Main St., Baltimore, Md.</p>	

RECEIVED

IN 2 1957

BUREAU A. 8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12099

CERTIFICATE OF DEATH

Reg. Dist. No. 42

12113

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1650 Sulphur Spring Rd</u>				d. STREET ADDRESS <u>1650 Sulphur Spring Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>C.</u> Last <u>Brocato</u>				4. DATE OF DEATH Month <u>12</u> Day <u>31</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/28/1886</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Italy</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Anthony Papa</u>				14. MOTHER'S MAIDEN NAME <u>Stella Marsiglia</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mr John Brete</u> Address <u>1650 Sulphur Spring Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer sigmoid Sigmoid</u> DUE TO <u>171x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senescent Carcinomatous</u> DUE TO <u>Cancer of Cervix</u> (c) <u>1-2-53</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>12-31-56</u> INTERVAL BETWEEN ONSET AND DEATH <u>11-25-55</u> <u>1-2-53</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6-35</u> , 19 <u>51</u> , to <u>12-31</u> , 19 <u>56</u> that I last saw the deceased alive on <u>12-31</u> , 19 <u>56</u> , and that death occurred at <u>10:30</u> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>S. Demarco Jr.</u> M.D.				PHYSICIAN'S NAME (Type) <u>S. Demarco Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cmn.</u>		22d. LOCATION (City, town, or county) (State) <u>4300 Old Redbank Rd</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Bowman & Son</u> ADDRESS <u>Gollins St.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 3 1957</u>		24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12128

CERTIFICATE OF DEATH

12100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6719 Linden Ave.		d. STREET ADDRESS 6719 Linden Ave.	
3. NAME OF DECEASED (Type or print) First Mary Middle Brown Last Brown		4. DATE OF DEATH Month December Day 20 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1889
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner-Retired		10b. KIND OF BUSINESS OR INDUSTRY Rooming House	11. BIRTHPLACE (State or foreign country) Balto. Co. Md.
13. FATHER'S NAME August Schmidt		14. MOTHER'S MAIDEN NAME Caroline Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-32-2812	
17. INFORMANT Mrs. Margaret B. Swift		Address 6719 Linden Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 24 Oct. 1956 to 20 Dec. 1956 , that I last saw the deceased alive on 20 Dec. 1956 , and that death occurred at 5:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE M. H. Brown		ADDRESS (Street, city or town, state) 6801 Belair Rd.	
PHYSICIAN'S NAME (Type)		DATE SIGNED 21 Dec 56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 24, 1956	22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Louahn Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR DEC 26 1956		24b. REGISTRAR'S SIGNATURE W. K. Raymond	

BUREAU V. 3

DEC 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

121014

12129 CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 3 Hrs. 40 Min. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Reisterstown c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown d. STREET ADDRESS 19 Delight Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First JOHN Middle H. Last BRUNETT		4. DATE OF DEATH Month December Day 6 Year 56					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1889	9. AGE (In years last birthday) yrs. 67	IF UNDER 1 YEAR Months 6 Days 19 Hours 56 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent-Retired		10b. KIND OF BUSINESS OR INDUSTRY County Roads		11. BIRTHPLACE (State or foreign country) York County, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John C. Brunnett		14. MOTHER'S MAIDEN NAME Sarah Householder					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW I 218-30-5923		17. INFORMANT Address Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Goiter. 2. Absence of left lung, acquired.						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3 PM		20f. (City or town) 6:40 PM (County) (State)	
21. I certify that I attended the deceased from December 6, 1956 to Dec. 6, 1956 , that I saw the deceased at 6:40 P. , and that death occurred at 6:40 P. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE C. J. Papastrat M.D. M.D. VAH, FORT HOWARD, MARYLAND 12/7/56 PHYSICIAN'S NAME (Type) C. J. PAPASTRAT, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Dec. 10/56		22c. NAME OF CEMETERY OR CREMATORY New Holland Luthern Cem.		22d. LOCATION (City, town, or county) (State) Lancaster County, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph F. Elme & Sons, Main St., Reisterstown			ADDRESS Maryland		24a. REC'D BY REGISTRAR DATE 12-8-56		24b. REGISTRAR'S SIGNATURE Wm. P. Shue

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BUREAU V. S.

DEC 10 1956

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12102

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6417 Walnut Ave				d. STREET ADDRESS 6417 Walnut Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Bernard Byrne Sr. First Middle Last				4. DATE OF DEATH DEC. Month Day Year 29 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 20 1900		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Ward Baking Co.		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas H. Byrne				14. MOTHER'S MAIDEN NAME Mary R. McNally			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-05-3356		17. INFORMANT Mrs. Mary Byrne Address 6417 Walnut Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Geo. S.M. Kieffer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Geo. S.M. Kieffer M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-2-57		22c. NAME OF CEMETERY OR CREMATORY NEW Cathedral		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.T. Stansbury				24a. REC'D BY REGISTRAR 1/2/56		24b. REGISTRAR'S SIGNATURE John E. Martin	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10105
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH	
PREVIOUS ILLNESS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY		PATHOLOGICAL FINDINGS	
TESTS		X-RAY		LABORATORY		AUTOPSY		TOXICOLOGY		OTHER	
SIGNATURE OF EXAMINER		TITLE		DATE		PLACE		HOURS		MINUTES	

BUREAU V. S.

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 JAN 4 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12103

12131

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. LENGTH OF STAY IN 1b 14 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		d. STREET ADDRESS 1234 Kahler Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1234 Kahler Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle W. Last Callaway		4. DATE OF DEATH Month December Day 29 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1872
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist-Retired		10b. KIND OF BUSINESS OR INDUSTRY Machine Shop	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Callaway		14. MOTHER'S MAIDEN NAME Elizabeth Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Mrs. Vesta Walters 1234 Kahler Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 45 minutes 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 53 , to Dec. 29 , 1956 , that I last saw the deceased alive on Dec. 29 , 1956 , and that death occurred at 5:20 p.m. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 8019 Philadelphia Road DATE SIGNED 12-31-56	
ACTUAL SIGNATURE James R. Mason, M.D.		PHYSICIAN'S NAME (Type) James R. Mason, M. D. Baltimore 6, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12-31-1956	
22c. NAME OF CEMETERY OR CREMATORY Green Mount		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassaku Funeral Home ADDRESS 7401 Belair Rd		24a. REC'D BY REGISTRAR Edith K... DATE 1957	
24b. REGISTRAR'S SIGNATURE			

BUREAU V. S.

JAN 2 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12104

12133

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgemere</u>				c. LENGTH OF STAY IN 1b <u>35 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2424 Carolyn Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>*</u> Last <u>Carnahan</u>				4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 9, 1901</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter helper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Consolidated Engr.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Carnahan</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Carnahan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-09-5729</u>		17. INFORMANT <u>Robert Donaldson</u>		Address <u>2424 Carolyn Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>332.2 Alcoholism</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M B Davis</u>				DATE SIGNED <u>12-22-1956</u>			
EXAMINER'S NAME (Type) <u>Melvin B. Davis M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 26, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dundalk Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Smith Bradley</u>				24a. REC'D BY REGISTRAR <u>DEC 27 1956</u>			
ADDRESS <u>Dundalk, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Lawson L. Farley</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DEC 27 1956

RECEIVED

12133

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armcast Nursing Home		d. STREET ADDRESS 118 Charmuth Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Pauline Middle F. Last Carter		4. DATE OF DEATH Month December , Day 8th Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April, 20th 1896
9. AGE (In years last birthday) yrs. 60		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Finance Officer-Veterans Adm.		10b. KIND OF BUSINESS OR INDUSTRY Connellsville Pa.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sheridan Archie Fogle		14. MOTHER'S MAIDEN NAME Lillie May Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-07-2301	
17. INFORMANT Mrs Samuel Mattingly		118 Charmuth Road Timonium Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Lung 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary Carcinoma of Uterus DUE TO (c) 3 yr		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 15 , 19 55 , to Nov 18 , 19 56 that I last saw the deceased alive on Dec 18 , 19 56 , and that death occurred at 12 noon , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F O'Donnell M.D.		ADDRESS (Street, city or town, state) 7501 York Rd DATE SIGNED 12/8/56	
PHYSICIAN'S NAME (Type) CHARLES F O'DONNELL		Tolson #4md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 11 1956	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James L. Lamon		4000 Liberty Hgts Avenue	
24a. REC'D BY REGISTRAR DEC 12 1956		24b. REGISTRAR'S SIGNATURE Mabel Gray	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. S.

DEC 12 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12106

CERTIFICATE OF DEATH

12134

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>	
TOWN <u>Carney</u>		LENGTH OF STAY (in this place) <u>Life</u>		TOWN <u>Carney</u>		TOWN <u>Carney</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2909 Cub Hill Rd.</u>				STREET ADDRESS (If rural give location) <u>2909 Cub Hill Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Michael</u> (Middle) <u>Edward</u> (Last) <u>Chubb</u>				(Month) <u>Dec.</u> (Day) <u>26</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Child</u>	8. DATE OF BIRTH <u>May 25, 1949</u>	9. AGE last birthday <u>7</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Ernest E. Chubb</u>				14. MOTHER'S MAIDEN NAME <u>Leonora G. Michel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mr. Ernest E. Chubb 2909 Cub Hill Rd.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
193x IMMEDIATE CAUSE (A) <u>New Blastoma - Generalized Metastases</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>JAN 1956</u>		19b. MAJOR FINDINGS OF OPERATION <u>Malignant New Blastoma</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. A. P. M.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 1955</u> to <u>12/25/56</u> that I last saw the deceased alive on <u>12/25/56</u> and that death occurred at <u>1 A</u> M, from the causes and on the date stated above. SIGNATURE <u>Joseph J. Cameron</u> DATE SIGNED <u>12/26/56</u> ADDRESS (Street, city, town, state) <u>M.D. 30 - CHANDELLE RD - BALTO, MD</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 28, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>DEC 27 1956</u>		REGISTRAR'S SIGNATURE <u>John M. Bacon</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Lawson Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 1955

DATE OF DEATH

BY WHOM DECLARED

PLACE OF DEATH

NAME OF DECEASED

DATE OF BIRTH

SEX

EDUCATION

RELATIONSHIP TO DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

RECEIVED

BUREAU V. S.

DEC 27 1955

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12135

CERTIFICATE OF DEATH

12107

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>118 Westowne Place</u>		d. STREET ADDRESS <u>118 Westowne Place</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>J.</u> Last <u>Cloney</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>9</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 29, 1888</u>
9. AGE (In years last birthday) yrs. <u>67</u>		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>John T. Cloney</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Danaher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Wm. C. Cloney</u>		Address <u>118 Westowne Place 28</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma, left ovary</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>7-26</u> , 19 <u>56</u> , to <u>12-9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-26</u> , 19 <u>56</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John F. Schaefer M.D.</u>		ADDRESS (Street, city or town, state) <u>401 Random Road Balto.</u>	
PHYSICIAN'S NAME (Type) <u>JOHN F. SCHAEFER M.D.</u>		DATE SIGNED <u>12-11-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-12-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto.</u> <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Salley Funeral Home - Catonsville 28, M.D.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 7</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>			

DEC 13 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12108

Item 8, Film G209, 1/7/57 fcy

12136
CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION York Rd.		d. STREET ADDRESS York Rd.	
3. NAME OF DECEASED (Type or print) First Alberta Middle May Last Cole		4. DATE OF DEATH Month 12-25-56 Day 19 Year 19	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-14-57
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 12 Days 25 Hours 56 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Thomas A. Ryan		14. MOTHER'S MAIDEN NAME Mary Etta Wisner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs. John C. Leight,		Address Monkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 900.0 (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of neck of right femur			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Fell down steps			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. Oct 1956 p. m. 8		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Monkton Baltimore Ind.	
21. I certify that I attended the deceased from Oct 1956 , to Dec. 25, 1956 , that I last saw the deceased alive on Dec. 24, 1956 , and that death occurred at 6 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE A. M. France		DATE SIGNED 12/27/56	
PHYSICIAN'S NAME (Type) A. M. FRANCE		ADDRESS (Street, city or town, state) Parkton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-27-56	22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Methodist	22d. LOCATION (City, town, or county) (State) Parkton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE I Scott Brooks		24a. REC'D BY REGISTRAR 29 Dec 1956	
ADDRESS 622 York Rd. Towson 4, Md.		24b. REGISTRAR'S SIGNATURE Gene Amistead MacRae	

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12137 2 FilmG209 1-8-57 et

12109

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>		LENGTH OF STAY (in this place) <u>2 mos</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		TOWN <u>Timonium</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Stella Marie Hospice</u>				STREET ADDRESS <u>1817 Rutland Avenue</u>			
3. NAME OF DECEASED (Type or Print) <u>Emma</u> (First) <u>Charry</u> (Middle) (Last)				4. DATE OF DEATH <u>12</u> <u>30</u> <u>1956</u> (Month) (Day) (Year)			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>3</u>	8. DATE OF BIRTH <u>AUG. 29, 1868</u>	9. AGE last birthday <u>88</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MARYLAND.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES CONROY</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET TIGHE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S ADDRESS <u>2206 EAST NORTH AVE. MRS GLADYS HADDON</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized atherosclerosis</u>				<u>10 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 8, 1955</u> to <u>Dec 30, 1956</u> , that I last saw the deceased alive on <u>Dec 30, 1956</u> , and that death occurred at <u>8:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles F. O'Donnell</u> M.D. <u>7501 York Rd - Timonium</u>				DATE SIGNED <u>4/30/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1/3/57</u>		NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL CEMETERY BALTIMORE MARYLAND.</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>James MacRae</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY SANDER & SONS INC.</u> ADDRESS <u>BALTIMORE MARYLAND</u>			
DATE <u>JAN 3 1957</u>							

CERTIFICATE OF DEATH

Reg. Off. No.

22. USUAL RESIDENCE, (SEE INSTRUCTIONS)

DATE OF DEATH
TIME OF DEATH

PLACE OF DEATH

REG. NO.
DEPT. OF HEALTH

CAUSE OF DEATH

ICD-9 CODE

SEX

THE MEDICAL EXAMINER

DEATH CERTIFICATE

1. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Vital Statistics.

2. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Vital Statistics.

3. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Vital Statistics.

4. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Vital Statistics.

5. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Vital Statistics.

6. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Vital Statistics.

7. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Vital Statistics.

8. I hereby certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Vital Statistics.

BUREAU V. 3

JAN 3 1957

RECEIVED

12138

CERTIFICATE OF DEATH

12110

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore, Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville				c. LENGTH OF STAY IN 1b 3yrs 5mth 25dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 1739 Park Avenue			
3. NAME OF DECEASED (Type or print) First Gail Middle Crossley Last Crossley				4. DATE OF DEATH Month December Day 4 Year 19 56			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 14, 1880		9. AGE (In years last birthday) yrs. 76	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY housework		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records Spring Grove State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus ulcers						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 5, 1956 , to Dec. 4, 1956 , that I last saw the deceased alive on Dec. 4, 1956 , and that death occurred at 8:40 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Louise Frances Woodward M.D.				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 12-4-56			
PHYSICIAN'S NAME (Type) Louise Frances Woodward, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Dec. 5/56		22c. NAME OF CEMETERY OR CREMATORY Tulsa, Okl.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry N. Witzke				ADDRESS 410 Edmondson av		24a. REC'D BY REGISTRAR DATE DEC 6 '56	
				24b. REGISTRAR'S SIGNATURE Overman			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. TREATMENT	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF WITNESS		18. SIGNATURE OF DECEASED		19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF REGISTRAR	

BUREAU V. 21

DEC 7 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12111

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mr. JOSEPH</u> First Middle Last		4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 6, 1901</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>	11. BIRTHPLACE (State or foreign country) <u>Germany</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>?</u>	
14. MOTHER'S MAIDEN NAME <u>?</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Maurice L. Elliott, 215 E. Fayette</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>420.0</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Russell S. Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Russell S. FISHER</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/24/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck 5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>DATE 27 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>Dr. J. M. Bacon</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - ATTORNEY
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 27 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12140

CERTIFICATE OF DEATH

Reg. Dist. No. 12112

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY BA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville				c. LENGTH OF STAY IN 1b 1mth 24dys			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland				d. STREET ADDRESS 213 Hance Avenue - Linthicum, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Modesto Middle D'Antonio Last D'Antonio				4. DATE OF DEATH Month December Day 5 Year 19 56			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1889	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months 5 Days 19 Hours 56	IF UNDER 24 HRS. Months 5 Days 19 Hours 56	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Gauntano D'Antonio				14. MOTHER'S MAIDEN NAME Nuzito D'Antonio			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition and dehydration 443X DUE TO Extreme cerebral atrophy Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Multiple old cerebral hemorrhages DUE TO (c) Hypertensive cardiovascular disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Oct. 11, 1956 , to Dec. 5, 1956 that I last saw the deceased alive on Dec. 5, 1956 , and that death occurred at 7:00p. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachsler				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL			
DATE SIGNED 12-6-56							
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) B		22b. DATE THEREOF 12/10/56		22c. NAME OF CEMETERY OR CREMATORY Holy Cross		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes - 130 E. Fort Ave.				ADDRESS		24a. REC'D BY REGISTRAR DEC 10 '56	
				24b. REGISTRAR'S SIGNATURE Rebecca			

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12141

CERTIFICATE OF DEATH

12113

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore-Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore-Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) Box 391 Bletzer Road		d. STREET ADDRESS 391 Bletzer Road	
3. NAME OF DECEASED (Type or print) First ADELE Middle F. Last DAVIS		4. DATE OF DEATH Month Dec. 28, Day 19 Year 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1876
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 80 Days 80 Hours 80 Min. 80	IF UNDER 24 HRS. Months 80 Days 80 Hours 80 Min. 80
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Ohio	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jack O'Donnell		14. MOTHER'S MAIDEN NAME Mary Kildaire	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Warner Fitch 391 Bletzer Road.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cause of Stroke 151X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 9 mos -	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 26, 1956 to Dec 23, 1956 , that I last saw the deceased alive on Dec 23, 1956 , and that death occurred at 2:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M.B. Davis		ADDRESS (Street, city or town, state) 6800 Morningside Ave. 12/29/56	
PHYSICIAN'S NAME (Type) M.B. DAVIS M.D.		DATE SIGNED Dundalk - Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 31, 1956	
22c. NAME OF CEMETERY OR CREMATORY Meadow Ridge Park		22d. LOCATION (City, town, or county) (State) Dorsey, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ulrich Funeral Home 2112 Dundalk Ave.		24a. REC'D BY REGISTRAR JAN 3 1957	
24b. REGISTRAR'S SIGNATURE John M. Kelly			

CERTIFICATE OF DEATH

<p>1. Name of deceased: DAVID</p>		<p>2. Sex: Male</p>	
<p>3. Date of birth: 1901</p>		<p>4. Date of death: 1967</p>	
<p>5. Place of birth: MD</p>		<p>6. Place of death: MD</p>	
<p>7. Cause of death: Heart Disease</p>		<p>8. Manner of death: Natural</p>	
<p>9. Signature of physician: [Signature]</p>		<p>10. Signature of registrar: [Signature]</p>	
<p>11. Date of filing: 1967</p>		<p>12. File number: 100-100000</p>	

BUREAU V. 3

JAN 8 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14, Film G209 116-57 et

12142

CERTIFICATE OF DEATH

12115

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore, MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home 1002 N. Rolling Road		d. STREET ADDRESS Hopkins Apartments	
3. NAME OF DECEASED (Type or print) First Nellie Middle Field Last Davis		4. DATE OF DEATH Month Dec. Day 21, Year 1956	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1877
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months 79 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Mo.	
11. BIRTHPLACE (State or foreign country) Mo.		12. CITIZEN OF WHAT COUNTRY? Md.	
13. FATHER'S NAME Dr. John Field		14. MOTHER'S MAIDEN NAME Emily Corbin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mr. Edward C. Golder 113 Melvin Ave. Catonsville	
17. INFORMANT Mr. Edward C. Golder 113 Melvin Ave. Catonsville		Address Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumo pneumonia 42227 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis DUE TO (c) Cerebral accident		INTERVAL BETWEEN ONSET AND DEATH 24 hrs years One year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio Sclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 1956 to Dec 21, 1956 , that I last saw the deceased alive on Dec 21, 1956 , and that death occurred at 9:50 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Wether Dec Fort.		ADDRESS (Street, city or town, state) 1118 St. Paul St.	
PHYSICIAN'S NAME (Type) Wether Dec Fort.		DATE SIGNED DEC 27 '56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 24, 1956	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons 1900 Eutaw Place		24a. REC'D BY REGISTRAR DATE DEC 27 '56	
24b. REGISTRAR'S SIGNATURE Wether Dec Fort.			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

DEC 27 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 5, Film G209, 1/7/57 for

CERTIFICATE OF DEATH

Reg. Dist. No.

12114
33

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Kent</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Orwings Mills, Md</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hennedysville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rosewood Training School</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Alice</i> Middle <i>Mae</i> Last <i>Dawkins</i>		4. DATE OF DEATH Month <i>12</i> Day <i>16</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/6/54</i>
9. AGE (In years last birthday) <i>2</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>	
13. FATHER'S NAME <i>Mr Louis Dawkins</i>		14. MOTHER'S MAIDEN NAME <i>Ann Mae Dawkins</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Rosewood Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Unknown</i> <i>Broncho pneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Tay Sachs disease</i> DUE TO (c) <i>Pneumonia (Broncho)</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12/16/56</i> , 1956, to <i>12/16/56</i> , 1956, that I last saw the deceased alive on <i>12/17/56</i> , 1956, and that death occurred at <i>7 am</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>WALTER T. ELLIEN</i> M.D.		Rosewood St. Tr. School	
PHYSICIAN'S NAME (Type) <i>Ellien</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec. 20-56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Rosewood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Orwings Mills</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J F Ellien Sons Ruston</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>12-20-56</i>		24b. REGISTRAR'S SIGNATURE <i>Mary B. Elina</i>	

BUREAU V. S.

DEC 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12144

CERTIFICATE OF DEATH

12116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>				c. LENGTH OF STAY IN 1b <u>3yr8mth28days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>Deeds</u> Last <u>Deeds</u>				4. DATE OF DEATH Month <u>December</u> Day <u>19</u> Year <u>19 56</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 4, 1872</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u>84</u> Days <u>19</u> Hours <u>56</u> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Parker</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Douglas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease with hypertension</u> (c) <u>hypertension</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile psychosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1, 1953</u> , to <u>Dec. 19, 1956</u> , that I last saw the deceased alive on <u>Dec. 19, 1956</u> , and that death occurred at <u>10:26 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachsler</u>		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>12-19-56</u>					
PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>		<u>Catonsville 28, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 24, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Merchantville, New Jersey.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>MASONE BRADLEY CAMDEN N. J.</u>				24a. REC'D BY REGISTRAR <u>DEC 26 '56</u>		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF CORONER</p>		<p>16. SIGNATURE OF JURY</p>	
<p>17. SIGNATURE OF DECEASED</p>		<p>18. SIGNATURE OF WITNESS</p>		<p>19. SIGNATURE OF PHYSICIAN</p>		<p>20. SIGNATURE OF CORONER</p>	
<p>21. SIGNATURE OF DECEASED</p>		<p>22. SIGNATURE OF WITNESS</p>		<p>23. SIGNATURE OF PHYSICIAN</p>		<p>24. SIGNATURE OF CORONER</p>	
<p>25. SIGNATURE OF DECEASED</p>		<p>26. SIGNATURE OF WITNESS</p>		<p>27. SIGNATURE OF PHYSICIAN</p>		<p>28. SIGNATURE OF CORONER</p>	
<p>29. SIGNATURE OF DECEASED</p>		<p>30. SIGNATURE OF WITNESS</p>		<p>31. SIGNATURE OF PHYSICIAN</p>		<p>32. SIGNATURE OF CORONER</p>	
<p>33. SIGNATURE OF DECEASED</p>		<p>34. SIGNATURE OF WITNESS</p>		<p>35. SIGNATURE OF PHYSICIAN</p>		<p>36. SIGNATURE OF CORONER</p>	
<p>37. SIGNATURE OF DECEASED</p>		<p>38. SIGNATURE OF WITNESS</p>		<p>39. SIGNATURE OF PHYSICIAN</p>		<p>40. SIGNATURE OF CORONER</p>	
<p>41. SIGNATURE OF DECEASED</p>		<p>42. SIGNATURE OF WITNESS</p>		<p>43. SIGNATURE OF PHYSICIAN</p>		<p>44. SIGNATURE OF CORONER</p>	
<p>45. SIGNATURE OF DECEASED</p>		<p>46. SIGNATURE OF WITNESS</p>		<p>47. SIGNATURE OF PHYSICIAN</p>		<p>48. SIGNATURE OF CORONER</p>	
<p>49. SIGNATURE OF DECEASED</p>		<p>50. SIGNATURE OF WITNESS</p>		<p>51. SIGNATURE OF PHYSICIAN</p>		<p>52. SIGNATURE OF CORONER</p>	
<p>53. SIGNATURE OF DECEASED</p>		<p>54. SIGNATURE OF WITNESS</p>		<p>55. SIGNATURE OF PHYSICIAN</p>		<p>56. SIGNATURE OF CORONER</p>	
<p>57. SIGNATURE OF DECEASED</p>		<p>58. SIGNATURE OF WITNESS</p>		<p>59. SIGNATURE OF PHYSICIAN</p>		<p>60. SIGNATURE OF CORONER</p>	
<p>61. SIGNATURE OF DECEASED</p>		<p>62. SIGNATURE OF WITNESS</p>		<p>63. SIGNATURE OF PHYSICIAN</p>		<p>64. SIGNATURE OF CORONER</p>	
<p>65. SIGNATURE OF DECEASED</p>		<p>66. SIGNATURE OF WITNESS</p>		<p>67. SIGNATURE OF PHYSICIAN</p>		<p>68. SIGNATURE OF CORONER</p>	
<p>69. SIGNATURE OF DECEASED</p>		<p>70. SIGNATURE OF WITNESS</p>		<p>71. SIGNATURE OF PHYSICIAN</p>		<p>72. SIGNATURE OF CORONER</p>	
<p>73. SIGNATURE OF DECEASED</p>		<p>74. SIGNATURE OF WITNESS</p>		<p>75. SIGNATURE OF PHYSICIAN</p>		<p>76. SIGNATURE OF CORONER</p>	
<p>77. SIGNATURE OF DECEASED</p>		<p>78. SIGNATURE OF WITNESS</p>		<p>79. SIGNATURE OF PHYSICIAN</p>		<p>80. SIGNATURE OF CORONER</p>	
<p>81. SIGNATURE OF DECEASED</p>		<p>82. SIGNATURE OF WITNESS</p>		<p>83. SIGNATURE OF PHYSICIAN</p>		<p>84. SIGNATURE OF CORONER</p>	
<p>85. SIGNATURE OF DECEASED</p>		<p>86. SIGNATURE OF WITNESS</p>		<p>87. SIGNATURE OF PHYSICIAN</p>		<p>88. SIGNATURE OF CORONER</p>	
<p>89. SIGNATURE OF DECEASED</p>		<p>90. SIGNATURE OF WITNESS</p>		<p>91. SIGNATURE OF PHYSICIAN</p>		<p>92. SIGNATURE OF CORONER</p>	
<p>93. SIGNATURE OF DECEASED</p>		<p>94. SIGNATURE OF WITNESS</p>		<p>95. SIGNATURE OF PHYSICIAN</p>		<p>96. SIGNATURE OF CORONER</p>	
<p>97. SIGNATURE OF DECEASED</p>		<p>98. SIGNATURE OF WITNESS</p>		<p>99. SIGNATURE OF PHYSICIAN</p>		<p>100. SIGNATURE OF CORONER</p>	

BUREAU V. 2

DEC 26 1956

RECEIVED

MASON E. FRIDLEY - BALTIMORE, MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12117

Reg. Dist. No.

12145

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. LENGTH OF STAY IN 1b 23 mo.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MAY Middle A. Last DEIBERT				4. DATE OF DEATH Month DECEMBER Day 29 Year 19 56			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 20, 1875	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 12 Days 24 Hours 2		IF UNDER 24 HRS. Hours 2 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Andrew Holt				14. MOTHER'S MAIDEN NAME Annie Burns			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT E. ROY DEIBERT		Address 207 HOWARD ST ELKTON, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardio vascular disease 936.7 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture of left hip accident DUE TO (c) Pending							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) has pushed down by another patient.			
20c. TIME OF INJURY Month, Day, Year Hour 6 o. m. 12-5-1956				20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital Catonsville Baltimore				20f. (City or town) (County) (State) Catonsville Baltimore Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Geo. S. M. Kieffer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Geo. S. M. KIEFFER				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-31-1956		22c. NAME OF CEMETERY OR CREMATORY Elkton Manor Mausoleum	
22d. LOCATION (City, town, or county) Elkton				(State) MD			
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Piffner				ADDRESS 254 E. Main St. Elkton Md.		24a. REC'D BY REGISTRAR W. C. Lushy	
				24b. REGISTRAR'S SIGNATURE W. C. Lushy		DATE JAN 4 '57	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-107

BUREAU V. S.

JAN 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12118

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FULLERTON				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4551 Ridge Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle MELVIN Last DIEHL				4. DATE OF DEATH Month DEC Day 25 Year 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr 13, 1912		9. AGE (In years last birthday) 44 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John M. Diehl				14. MOTHER'S MAIDEN NAME Mary Jane Diehl			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-20-4562		17. INFORMANT Wife-Evelyn Address 4550 Ridge Rd Balto 6 MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-thrombo-embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intra cardiac thrombus DUE TO (c) Rheumatic Cardio Vascular Disease Severe							INTERVAL BETWEEN ONSET AND DEATH Immed. undeter 20yrs +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John C. Hyle</i> EXAMINER'S NAME (Type) JOHN C. HYLE MD				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 12-25-56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/56		22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		22d. LOCATION (City, town, or county) (State) Taylor Ave. Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc				ADDRESS 6009 Harford Rd		24a. REC'D BY REGISTRAR DATE 2 1957	
				24b. REGISTRAR'S SIGNATURE <i>Mrs A. L. Thompson</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JAN 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12147

CERTIFICATE OF DEATH

12119 31

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Swynn Oak</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Chilpsburg Home</u>		d. STREET ADDRESS <u>5837 Belair Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Wm Henry Dietz</u>		4. DATE OF DEATH <u>Dec 5 1956</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 11, 1865</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Dietz</u>		14. MOTHER'S MARDEN NAME <u>Barbara Godfried</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		17. INFORMANT <u>Records Aug Home Campfielder</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Arterio-sclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>(2) - Fistula in Anus</u> (c) <u>1 yr.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 23, 1953</u> , to <u>Dec 5, 1956</u> , that I last saw the deceased alive on <u>Nov. 29, 1956</u> , and that death occurred at <u>12:44 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl L. Chambers</u> M.D.		ADDRESS (Street, city or town, state) <u>4108 Liberty St</u> DATE SIGNED <u>12/5/56</u>	
PHYSICIAN'S NAME (Type) <u>DR. EARL L. CHAMBERS</u>		<u>BALTIMORE - 7 - MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-7-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Ceme</u>		22d. LOCATION (City, town, or county) (State) <u>Balto md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul Clewman</u>		ADDRESS <u>6067 Hayford Rd</u>	
24a. REC'D BY REGISTRAR <u>Dr Jm. E. Martin</u>		24b. REGISTRAR'S SIGNATURE <u>Dr Jm. E. Martin</u>	

BUREAU V. S.

REC 7 1956

RECEIVED

Item 2, Film G209, 1/7/57 for **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 26 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville, Md. Phoenix P.O., Md.			
f. STREET ADDRESS Baltimore County Home				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Dixon Last Dixon				4. DATE OF DEATH Month December Day 26 Year 19 56			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unknown	
9. AGE (In years last birthday) 75? yrs.		IF UNDER 1 YEAR Months 75? Days 75? Hours 75? Min. 75?		IF UNDER 24 HRS. Months 75? Days 75? Hours 75? Min. 75?			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown				10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Maryland ?	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME George Dixon?				14. MOTHER'S MAIDEN NAME May Swann?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown				16. SOCIAL SECURITY NO. unknown			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized and severe DUE TO (c) Arteriosclerosis, generalized and severe							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized and severe							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 30 , 19 56 , to Dec. 26 , 19 56 that I last saw the deceased alive on Dec. 26 , 19 56 , and that death occurred at 11:45a M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar				ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 12-26-56			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 12-29-56			
22c. NAME OF CEMETERY OR CREMATORY MT OLIVET				22d. LOCATION (City, town, or county) (State) BALTO. MD			
23. FUNERAL DIRECTOR'S SIGNATURE Paul E. Cheneau				24a. REC'D BY REGISTRAR DEC 31 1956			
ADDRESS 3615-17-19 E. Chestnut Ave				24b. REGISTRAR'S SIGNATURE DEC 31 1956			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. PLACE OF DEATH</p>		<p>10. DATE OF DEATH</p>		<p>11. TIME OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>		<p>13. SIGNATURE OF WITNESSES</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF REGISTRAR</p>	
<p>16. NAME OF DECEASED</p>		<p>17. SEX</p>		<p>18. AGE</p>		<p>19. DATE OF BIRTH</p>		<p>20. PLACE OF BIRTH</p>		<p>21. OCCUPATION</p>		<p>22. CAUSE OF DEATH</p>		<p>23. MANNER OF DEATH</p>		<p>24. PLACE OF DEATH</p>		<p>25. DATE OF DEATH</p>		<p>26. TIME OF DEATH</p>		<p>27. SIGNATURE OF DECEASED</p>		<p>28. SIGNATURE OF WITNESSES</p>		<p>29. SIGNATURE OF PHYSICIAN</p>		<p>30. SIGNATURE OF REGISTRAR</p>	

RECEIVED

DEC 31 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12149

CERTIFICATE OF DEATH

12120

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>✓</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore #23</i>	
c. LENGTH OF STAY IN 1b <i>14 days</i>		3v01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Spring Grove St. Hospital</i>		d. STREET ADDRESS <i>1531 W Lombard</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>WILLIAM W.</i> Middle <i>DISE</i> Last <i>DIZE</i>		4. DATE OF DEATH Month <i>12</i> / Day <i>7</i> / Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/2/69</i>
9. AGE (In years last birthday) <i>87</i> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <i>8</i> Days <i>7</i> Hours <i>19</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>car repairman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Rail Road</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Dise DIZE</i>		14. MOTHER'S MAIDEN NAME <i>Sally; maiden name unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>This Hospital's Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart failure</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary sclerosis</i> DUE TO (c) <i>Generalized arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i> <i>few years</i> <i>few years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fracture of right hip, old</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov. 23, 1956</i> , to <i>Dec. 7, 1956</i> , that I last saw the deceased alive on <i>Dec. 6, 1956</i> , and that death occurred at <i>5:55 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Bruno Radauskas</i> M.D.		ADDRESS (Street, city or town, state) <i>Spring Grove St. Hosp.</i>	
DATE SIGNED <i>12/7/1956</i>			
PHYSICIAN'S NAME (Type) <i>BRUNO RADAUSKAS</i>		<i>as above.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>DEC. 9/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>FRANKTOWN</i>		22d. LOCATION (City, town, or county) (State) <i>VA.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harry H Witzke</i>		ADDRESS <i>4101 Edmondson Ave</i>	
24a. REC'D BY REGISTRAR <i>DEC 10 '56</i>		24b. REGISTRAR'S SIGNATURE <i>W. Beach</i>	

BUREAU V. S.

DEC 10 1953

RECEIVED
DEC 10 1964

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

STATE OF MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12122

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Pt.</u>				c. LENGTH OF STAY IN 1b <u>3-2 YRS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>847 F ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>(NM)</u> Last <u>DANKO, JR</u>				4. DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>MAR. 5, 1883</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL MFR</u>		11. BIRTHPLACE (State or foreign country) <u>HUNGARY</u>	
13. FATHER'S NAME <u>UNK.</u>				14. MOTHER'S MAIDEN NAME <u>UNK.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or both) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>313-07-4687</u>			
17. INFORMANT <u>DET. STEEL</u> Address <u>CO. (19)</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CA. of Prostate</u> DUE TO <u>177x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Asthma</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>—</u> a. m. <u>—</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack C Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Jack C Collins</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>12-10-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO., MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brooks Bradley, Rudolph, MD</u>				24. REC'D BY REGISTRAR <u>—</u> 24a. REGISTRAR'S SIGNATURE <u>Dawson L. Furberg</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF JURY		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

BUREAU V. S.

DEC 11 1956

RECEIVED

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12151

CERTIFICATE OF DEATH

12123

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RODGERS FORGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RODGERS FORGE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>202 REGISTER AVE</u>		d. STREET ADDRESS <u>202 REGISTER AVE</u>	
3. NAME OF DECEASED (Type or print) <u>First Elizabeth M. Last DONOVAN</u>		4. DATE OF DEATH <u>DEC 22 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 6, 1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ASS. SECRETARY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING LOAN ASS.</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>CHARLES N. MILLER</u>		14. MOTHER'S MAIDEN NAME <u>MARY NOLAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-14-5710</u>	
17. INFORMANT <u>J. Ralph DONOVAN</u>		Address <u>202 REGISTER AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>With Generalized Metastasis</u> DUE TO (c) <u>5 1/2 yrs.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUNE 1947</u> to <u>December 24, 1956</u> , that I last saw the deceased alive on <u>December 24, 1956</u> and that death occurred at <u>7:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		ADDRESS (Street, city or town, state) <u>7501 7th Rd. Towson Md</u>	
DATE SIGNED <u>1/31/57</u>			
PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell M.D.</u>		<u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-27-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ganev</u>		ADDRESS <u>8802 Maryland Rd</u>	
24a. REC'D BY REGISTRAR <u>1/31/57</u>		24b. REGISTRAR'S SIGNATURE <u>Nabel C. Gray</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED

DEC 31 1956

BUREAU V. 81

1. NAME OF DECEASED [Faint handwritten name]		2. SEX [Faint handwritten sex]		3. AGE [Faint handwritten age]		4. RACE [Faint handwritten race]		5. DATE OF BIRTH [Faint handwritten date]		6. PLACE OF BIRTH [Faint handwritten place]	
7. MARITAL STATUS [Faint handwritten status]		8. OCCUPATION [Faint handwritten occupation]		9. CAUSE OF DEATH [Faint handwritten cause]		10. MANNER OF DEATH [Faint handwritten manner]		11. SIGNATURE OF PHYSICIAN [Faint handwritten signature]		12. SIGNATURE OF REGISTRAR [Faint handwritten signature]	
13. PLACE OF DEATH [Faint handwritten place]		14. COUNTY [Faint handwritten county]		15. CITY [Faint handwritten city]		16. STATE [Faint handwritten state]		17. ZIP CODE [Faint handwritten zip]		18. DATE OF DEATH [Faint handwritten date]	
19. SIGNATURE OF DECEASED [Faint handwritten signature]		20. SIGNATURE OF WITNESS [Faint handwritten signature]		21. SIGNATURE OF PHYSICIAN [Faint handwritten signature]		22. SIGNATURE OF REGISTRAR [Faint handwritten signature]		23. SIGNATURE OF CLERK [Faint handwritten signature]		24. SIGNATURE OF CHIEF OF BUREAU [Faint handwritten signature]	

CERTIFICATE OF DEATH

Reg. Dist. No.

12152

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>batonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Baton Ridge Home</i>		d. STREET ADDRESS <i>3809 Oakford Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>ESTHER</i> Middle <i>-</i> Last <i>DORTCH</i>		4. DATE OF DEATH Month <i>12</i> Day <i>4</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>32</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hair Dresser</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>32</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Max Dortch</i>		14. MOTHER'S MAIDEN NAME <i>Jennie</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Max Dortch - same</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>barrenness of the Ovary</i> <i>153x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Barrenness of Ovaries</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>6 mo.</i> <i>2 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec 4</i> to <i>Dec 4</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Dec 4</i> , 19 <i>56</i> , and that death occurred at <i>9:00 p.m.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Lester N. Kolman</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>Baltimore 15, Maryland 12-5-56</i>	
PHYSICIAN'S NAME (Type) <i>Lester N. Kolman, M.D.</i>		3700 Park Heights Avenue	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>12-6-56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt Carmel</i>	22d. LOCATION (City, town, or county) (State) <i>Balto Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis</i>		ADDRESS <i>2100 Eutaw Place</i>	
24a. REC'D BY REGISTRAR <i>DEC 7</i>		24b. REGISTRAR'S SIGNATURE <i>Paul Smith</i>	

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
HOURS		CITY	
DAY		COUNTY	
MONTH		STATE	
YEAR		COUNTRY	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARRIED		SINGLE	
WIDOWED		DIVORCED	
SEPARATED		UNKNOWN	
CAUSE OF DEATH		MANNER OF DEATH	
IMMEDIATE		INTERMEDIATE	
FINAL		OTHER	
PLACE OF BIRTH		PLACE OF DEATH	
CITY		CITY	
COUNTY		COUNTY	
STATE		STATE	
COUNTRY		COUNTRY	
DATE OF BIRTH		DATE OF DEATH	
HOURS		HOURS	
DAY		DAY	
MONTH		MONTH	
YEAR		YEAR	
AGE		AGE	
SEX		SEX	
RACE		RACE	
RELIGION		RELIGION	
EDUCATION		EDUCATION	
OCCUPATION		OCCUPATION	
MARRIED		MARRIED	
SINGLE		SINGLE	
WIDOWED		WIDOWED	
DIVORCED		DIVORCED	
SEPARATED		SEPARATED	
UNKNOWN		UNKNOWN	
CAUSE OF DEATH		CAUSE OF DEATH	
IMMEDIATE		IMMEDIATE	
INTERMEDIATE		INTERMEDIATE	
FINAL		FINAL	
OTHER		OTHER	

BUREAU V. S.

DEC 7 1956

RECEIVED

12153

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wayne Nursing Home		d. STREET ADDRESS 1633 Freedom Way, North	
3. NAME OF DECEASED (Type or print) First Maude Middle A Last Doxen		4. DATE OF DEATH Month Dec. Day 27 Year 19 56	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 2, 1879
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John McFarland		14. MOTHER'S MAIDEN NAME ???	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mr. Walter Sims		Address 3437 Elmora Ave. Balto 13, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hip Fracture Subtrochanteric left. 904.7 DUE TO Ulcerations Extensive from cast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) left lower extremity. DUE TO Decubiti Sacrum & heels. (c) open Redaction Hip fracture left.		INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) open Redaction Hip fracture left.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II a (item 18).) Fall in Nursing Home	
20c. TIME OF INJURY Month, Day, Year Hour 200 p. m. 11/13/56		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nursing Home		20f. (City or town) (County) (State) Catonsville 28 md	
21. I certify that I attended the deceased from Jun 2, 1955 to Dec 27, 1956 that I last saw the deceased alive on 12/27/56 , 19 56 , and that death occurred at 6:45 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 1303 Frederick Rd DATE SIGNED 12/28/56	
ACTUAL SIGNATURE W. E. Mc Greth		M.D. 1303 Frederick Rd	
PHYSICIAN'S NAME (Type) W. E. Mc Greth		Catonsville 28 md	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF Dec. 31, 1956	22c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery	22d. LOCATION (City, town, or county) (State) Centerville Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home		ADDRESS 4210 Belair Rd.	
24a. REC'D BY REGISTRAR JAN 3 '57		24b. REGISTRAR'S SIGNATURE W. E. Mc Greth	

CERTIFICATE OF DEATH

Two Duplicates

LOCALITY OF DEATH		COUNTY	
DATE OF DEATH		HOUR OF DEATH	
PLACE OF DEATH		NATURE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARITAL STATUS		PREVIOUS ILLNESS	
DATE OF BIRTH		PLACE OF BIRTH	
PARENTS		SIBLINGS	
SPOUSE		CHILDREN	
GRANDCHILDREN		OTHER RELATIVES	
DEATH CERTIFICATE NO.		REGISTERED	
DATE OF REGISTRATION		PLACE OF REGISTRATION	
SIGNATURE OF REGISTRAR		OFFICIAL SEAL	
DATE		PLACE	

BUREAU V. S.

JAN 3 1957

RECEIVED

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12151

CERTIFICATE OF DEATH

12126

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Hart</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>64 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>Edgewood Box 62</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>R.</u> Last <u>DOXZEN</u>				4. DATE OF DEATH Month <u>December</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 29, 1896</u>	
9. AGE (In years last birthday) <u>60 yrs.</u>		IF UNDER 1 YEAR Months <u>60</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Edgewood Arsenal</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Daniel H. Doxzen</u>				14. MOTHER'S MAIDEN NAME <u>Ida McCabe (McKAY)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>- -</u>		17. INFORMANT <u>Clin. Rec., Vet. Adm. Hosp. Ft. Howard, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF LUNG WITH GENERALIZED METASTASES</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. g. <u>VA</u> 19 p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>VA</u>				20g. (County) <u>VAH</u>		20h. (State) <u>MARYLAND</u>	
21. I certify that I attended the deceased from <u>Oct. 22</u> 19 <u>56</u> , to <u>Dec. 25</u> 19 <u>56</u> , and that death occurred at <u>6:25 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald D. Mark</u>				ADDRESS (Street, city or town, state) <u>VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>12/26/56</u>	
PHYSICIAN'S NAME (Type) <u>DONALD D. MARK, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-28-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer W. Conklin</u>				ADDRESS <u>5444 Belair Rd. Balto. Md</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	
24b. REGISTRAR'S SIGNATURE <u>Donna L. Taylor</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 27 1956

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HAY		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1891		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION None		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1915		9. PLACE OF MARRIAGE Baltimore, Md.		10. NAME OF SPOUSE Mary H. HAY	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. DATE OF DEATH 1956		14. PLACE OF DEATH Home		15. SIGNATURE OF PHYSICIAN J. H. HAY	
16. SIGNATURE OF DECEASED JAMES H. HAY		17. SIGNATURE OF WITNESS Mary H. HAY		18. SIGNATURE OF PHYSICIAN J. H. HAY		19. SIGNATURE OF CLERK J. H. HAY		20. SIGNATURE OF REGISTRAR J. H. HAY	

(W-HAY)

BUREAU V. 2

DEC 28 1956

RECEIVED

12155

CERTIFICATE OF DEATH

Reg. No. 1212731

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODLAWN				c. LENGTH OF STAY IN 1b 45 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 184 DOGWOOD RD				e. STREET ADDRESS 184 DOGWOOD RD			
3. NAME OF DECEASED (Type or print) First Middle Last ERNIE (N.M.I.) DUVALL				4. DATE OF DEATH Month Day Year DECEMBER 2 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 8 1876	
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME EDWARD C. WIDERMANN				14. MOTHER'S MAIDEN NAME SALLY J. RITTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. CATHERINE DOROFF Address 5630 ASHBORNE ROAD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE LEFTS. DE DUE TO 171X (b) METASTATIC CARCINOMA - BOTH LUNGS ETC. DUE TO PRIMARY CARCINOMA CERVIX (c) PRIMARY CARCINOMA CERVIX						INTERVAL BETWEEN ONSET AND DEATH 1 DAY 6 Mo. 2 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from JUNE , 19 54 , to DEC. 2 , 19 56 , that I last saw the deceased alive on DEC. 2 , 19 56 , and that death occurred at 2:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. V. HODCK JR.				DATE SIGNED DEC. 4 1956			
PHYSICIAN'S NAME (Type) R. V. HODCK JR.				ADDRESS (Street, city or town, state) Liberty Rd. Sykesville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 5, 1956		22c. NAME OF CEMETERY OR CREMATORY WOODLAWN		22d. LOCATION (City, town, or county) (State) BALTIMORE MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Emilio, Inc. 1328 Sulphur Spring Rd.				24a. REC'D BY REGISTRAR DEC 6 1956		24b. REGISTRAR'S SIGNATURE Dr. Wm. E. Martin	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
PLACE OF DEATH		CITY		COUNTY		STATE		HOSPITAL	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH	
MANNER OF DEATH		PERMANENT		TEMPORARY		ACUTE		CHRONIC	
PREVIOUS ILLNESS		TREATMENT		SURGEON		PHYSICIAN		PATHOLOGIST	
FAMILY HISTORY		SOCIAL HISTORY		HISTORICAL		PHYSICAL		LABORATORY	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF PATHOLOGIST		SIGNATURE OF SURGEON	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

DEC 6 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12128

Reg. Dist. No.

12156

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. STREET ADDRESS <u>3335 Elm Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>A</u> Last <u>ERNST</u>		4. DATE OF DEATH Month <u>December</u> Day <u>22</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/12/84</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Ernst</u>		14. MOTHER'S MAIDEN NAME <u>Mary Heifs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>216-67-6897</u>	
17. INFORMANT <u>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>INDEFINITE</u> <u>INDEFINITE</u> <u>INDEFINITE</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL THROMBOSIS WITH RIGHT HEMIPLEGIA</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. ft.</u> <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 18, 19 56</u> , to <u>December 22, 19 56</u> , that I last saw the deceased alive on <u>December 19, 19 56</u> , and that death occurred at <u>12:05 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Veterans Administration Hospital</u> DATE SIGNED <u>12/22/56</u>			
ACTUAL SIGNATURE <u>Armen Bogosian</u>		M.D. <u>Veterans Administration Hospital</u>	
PHYSICIAN'S NAME (Type) <u>ARMEN BOGOSIAN, M. D.</u>		<u>Fort Howard, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/24/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Austin E. Donovan</u>		24a. REC'D BY REGISTRAR <u>DEC 26 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Donovan</u>		24c. REGISTRAR'S SIGNATURE <u>Donovan</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12157

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Raspburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Raspburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1202 62nd St			
3. NAME OF DECEASED (Type or print) First John J Middle Ferger Last Sr				4. DATE OF DEATH Month Dec Day 5 Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 8 1900		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cheuffer		10b. KIND OF BUSINESS OR INDUSTRY S K Co meat packer		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Adolph Ferger				14. MOTHER'S MAIDEN NAME Anna Tekays			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Mattie Ferger 1202 62nd St			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) metastasis to rt. hep							INTERVAL BETWEEN ONSET AND DEATH 6 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 25 , 19 55 , to Dec 5 , 19 56 , that I last saw the deceased alive on Dec 4 , 19 56 , and that death occurred at 4:4 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE G. A. Kolodny				ADDRESS (Street, city or town, state) 1825 Eastern Blvd		DATE SIGNED 12/6/56	
PHYSICIAN'S NAME (Type) A. L. KOLODNY, MD				1825 Eastern Blvd			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Dec 8/56		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Baltimore Co	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road				24a. REC'D BY REGISTRAR DEC 7 1956		24b. REGISTRAR'S SIGNATURE Mrs. L. L. Hefner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 10 1956

RECEIVED

CERTIFICATE OF DEATH

12158

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY OR TOWN <u>TIMONIUM</u>		LENGTH OF STAY (in this place) <u>2 yrs</u>		CITY OR TOWN <u>Balto</u>		CITY OR TOWN <u>3001-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>STELLA MARIS HOSPICE</u>				STREET ADDRESS <u>3010 Clifton Ave</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Clarence</u> (Middle) <u>Archibald</u> (Last) <u>FIFER</u>				(Month) <u>12</u> (Day) <u>5</u> (Year) <u>19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>5-26-69</u>	9. AGE last birthday <u>87</u> yrs.	10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.
				Months		Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Passenger Agent R.R.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Archibald Stewart Fifer</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Grant</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
						<u>Mr. Clarence A. Fifer, Plymouth 5317</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
430.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				3 Wks.			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Atherosclerosis</u>				10 yrs.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-15</u> , 19 <u>54</u> , to <u>12-3</u> 19 <u>56</u> , that I last saw the deceased alive on <u>12-3</u> , 19 <u>56</u> , and that death occurred at <u>2:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles E. Donnell</u>				ADDRESS (Street, city, town, state) <u>7501 York Rd. Towson 3756</u>			
DATE THEREOF <u>12/8/56</u>				NAME OF CEMETERY OR CREMATORY <u>Green Mount Cem.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				LOCATION (City, town, or county) <u>Baltimore, Maryland</u>			
24. REC'D BY REGISTRAR <u>1956</u> REGISTRAR'S SIGNATURE <u>Anne MacLay</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road.</u>			

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-35 10M

CERTIFICATE OF DEATH

Birth Date: 18

1912

PLACE OF BIRTH

MARYLAND

1. PLACE OF BIRTH (HOSPITAL OR HOME)

CO. 11

2. PLACE OF BIRTH (HOSPITAL OR HOME)

3. PLACE OF BIRTH (HOSPITAL OR HOME)

4. PLACE OF BIRTH (HOSPITAL OR HOME)

5. PLACE OF BIRTH (HOSPITAL OR HOME)

6. PLACE OF BIRTH (HOSPITAL OR HOME)

7. PLACE OF BIRTH (HOSPITAL OR HOME)

8. PLACE OF BIRTH (HOSPITAL OR HOME)

9. PLACE OF BIRTH (HOSPITAL OR HOME)

10. PLACE OF BIRTH (HOSPITAL OR HOME)

11. PLACE OF BIRTH (HOSPITAL OR HOME)

12. PLACE OF BIRTH (HOSPITAL OR HOME)

13. PLACE OF BIRTH (HOSPITAL OR HOME)

14. PLACE OF BIRTH (HOSPITAL OR HOME)

15. PLACE OF BIRTH (HOSPITAL OR HOME)

16. PLACE OF BIRTH (HOSPITAL OR HOME)

17. PLACE OF BIRTH (HOSPITAL OR HOME)

18. PLACE OF BIRTH (HOSPITAL OR HOME)

BUREAU V. 1

DEC 2 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12131

12159

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Md.				c. LENGTH OF STAY IN 1b 24 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 1921 E. Fairmont Ave.				3v01-4			
3. NAME OF DECEASED (Type or print) First MORTON Middle Last FINE				4. DATE OF DEATH Month 12 Day 16 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/25/27	
9. AGE (In years last birthday) 29 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Abraham Fine		14. MOTHER'S MAIDEN NAME Dora Berman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT Rosewood Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Alcoholosis, Dehydration 571.1 DUE TO Infections Diarrhea Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Idiocy DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12/14/1956 to 12/16/1956 , that I last saw the deceased alive on 12/16/1956 , and that death occurred at 10:10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Ernest J. Decker M.D. Dec. 16, 1956				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) ERNEST J. DECKO ROSEWOOD, OWING MILLS Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-17-56		22c. NAME OF CEMETERY OR CREMATORY Mt Carmel		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis Inc 2100 Eutaw Place				24a. REC'D BY REGISTRAR DEC 19 1956		24b. REGISTRAR'S SIGNATURE Mary Elmer	

MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

BUREAU V.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12132

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Washington				c. LENGTH OF STAY IN 1b At Work			
d. NAME OF HOSPITAL OR INSTITUTION. (If not in hospital, give street address) Catalyst Research Corp. 6101 Falls Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RAYMOND Middle FITZBERGER SR. Last FITZBERGER SR.				4. DATE OF DEATH Month December Day 6 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1906	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months 50 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard			10b. KIND OF BUSINESS OR INDUSTRY Catalyst Research		11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME Frederick Fitzberger			14. MOTHER'S MAIDEN NAME Mary				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-03-9348		17. INFORMANT John Fitzberger			
				Address 1914 Smith Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Decompensation gradient CWKS DUE TO (c) CWKS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NO							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Charles F. O'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 12-7-56		
EXAMINER'S NAME (Type) Charles F. O'Donnell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 10, 1956	22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		22d. LOCATION (City, town, or county) (State) Towson, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Burgess Funeral Home			ADDRESS 3631 Falls Road Balto 11		24a. REC'D BY REGISTRAR DATE 10 1956		
					24b. REGISTRAR'S SIGNATURE Dorothy Newell		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 5

DEC 10 1956

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. Middle River - 20</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>none</u>				d. STREET ADDRESS <u>15-B WESTWAY NORTH</u>			
3. NAME OF DECEASED (Type or print) First <u>MARK</u> Middle <u>T</u> Last <u>FLYNN</u>				4. DATE OF DEATH Month <u>12</u> - Day <u>20</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>13-5-28</u>	
9. AGE (In years last birthday) <u>28</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TOOL MAKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AIR CRAFT</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>MARK FLYNN</u>				14. MOTHER'S MAIDEN NAME <u>VERNA ROWE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>182-22-9368</u>		17. INFORMANT <u>ELIZABETH FLYNN</u> Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>STRANGULATION Due to HANGING</u> DUE TO <u>((Self)inflicted)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>HUNG Self to tree limb.</u>			
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>North Ave. - Middle River - Baltimore</u>		20f. (City or town) (County) (State) <u>BALTO.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M.B. Davis</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M.B. DAVIS M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-22-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART OF JESUS</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO.</u>	
23. MEDICAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>1407 Eastern Ave</u>		24a. REC'D BY REGISTRAR DATE <u>12/22/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Photograph by J. J. Carter for
10-25-56 SHARED HEART OF DEATH

RECEIVED

DEC 26 1956

BUREAU V. 3

NO 102-25-28612 ABETH FLYNN GAME

MARK FLYNN

VERNA ROWE

TECH. MARKER

AIR CRAFT

PENNA.

U 2 A.

MALE WHITE

10-2-56 38

15-B WESTWAY NORTH

MIDDLE RIVER

BALTO

419

5

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12-2-56
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12134

12162

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Milford				c. LENGTH OF STAY IN 1b 1 1/2 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3604 Durley Lane				d. STREET ADDRESS 3604 Durley Lane			
3. NAME OF DECEASED (Type or print) Mary M. Foote				4. DATE OF DEATH Month Dec. Day 22 Year 1956.			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 21, 1883	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Robert M. Clark				14. MOTHER'S MAIDEN NAME Amelia Goldhammer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Henry R. Fenker 3604 Durley Lane			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO (b) Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Chn. Valvular Heart Disease							INTERVAL BETWEEN ONSET AND DEATH 1945 1948
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 10, 1958 , to Dec 22, 1956 , that I last saw the deceased alive on Dec 22, 1956 , and that death occurred at 12:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul Brown				ADDRESS (Street, city or town, state) 3602 Liberty Rd. Ar.			
PHYSICIAN'S NAME (Type) Paul Brown - MD				DATE SIGNED 12/22/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-24-1956		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park		22d. LOCATION (City, town, or county) (State) Woodlawn Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard Strong				ADDRESS 3707 W North Ave.		24a. REC'D BY REGISTRAR DATE DEC 26 1956	
				24b. REGISTRAR'S SIGNATURE Dr. Wm. E. Martin			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 26 1956

BUREAU V. 3

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1956

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1213538

12163

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7804 Clarksworth Place</i>		d. STREET ADDRESS <i>7804 Clarksworth Place</i>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Laura Elizabeth Forrest</i>		4. DATE OF DEATH Month <i>December</i> Day <i>7th</i> Year <i>1956</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 2, 1871</i>
9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>August Kuhne</i>		14. MOTHER'S MAIDEN NAME <i>Marguerite Raab</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Ralph Winter, 7804 Clarksworth Pl.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>A.H. CVD CORONARY Insufficiency</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>20 YRS.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8-14, 1956</i> to <i>12-6, 1956</i> that I last saw the deceased alive on <i>12-6, 1956</i> and that death occurred on <i>12-6, 1956</i> at <i>11:17 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Anthony F. Carozza</i>		ADDRESS (Street, city or town, state) <i>5217 YORK Rd</i> DATE SIGNED <i>12/7/56</i>	
PHYSICIAN'S NAME (Type) <i>Anthony F. Carozza</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/10/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR <i>DEC 10 1956</i>		24b. REGISTRAR'S SIGNATURE <i>L. H. M. B.</i>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF DECEASED [Faint text]	
SIGNATURE OF NEXT OF KIN [Faint text]		SIGNATURE OF BURIAL SOCIETY [Faint text]	
SIGNATURE OF FUNERAL HOME [Faint text]		SIGNATURE OF CEMETERY [Faint text]	
SIGNATURE OF CHURCH [Faint text]		SIGNATURE OF OTHER [Faint text]	

BUREAU V. S.

DEC 10 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third-copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12136

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN <u>29</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN <u>29</u> STREET ADDRESS (If rural give location) <u>104 Malbrook Rd.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Mary Maxwell Hayslett</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 3, 1956</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>2-3-1870</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas C. Maxwell</u>				14. MOTHER'S MAIDEN NAME <u>Annie Barlow</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Louis Shipley 104 Malbrook Rd.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Acute Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>				unknown			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Diabetes Mellitus</u>				about 25 yrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>48</u> to <u>Dec. 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 3</u> , 19 <u>56</u> , and that death occurred at <u>10:30 P.</u> from the causes and on the date stated above.							
SIGNATURE <u>Leo J. Gavan</u>				ADDRESS (Street, city, town, state) <u>1 Mallow Hill Ave., Baltimore 29, Md</u>			
DATE SIGNED <u>12/4/56</u>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>12-6-56</u>		NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		LOCATION (City, town, or county) (State) <u>Hydenville, Md.</u>	
24. REC'D BY REGISTRAR <u>DEC 6 1956</u>		REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u>		ADDRESS <u>Hydenville, Md.</u>	

CERTIFICATE OF DEATH

Street in City but houses
in Co- 12/6/56 per G.T.E. + M.O.

BUREAU V. 2

EC 6 1956

RECEIVED

INSTRUCTIONS

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

12137

12165

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Balto.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>COCKEYSVILLE</u>		LENGTH OF STAY (In this place) <u>14 YEARS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>REISTERSTOWN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MASONIC HOME</u>				STREET ADDRESS (If rural give location) <u>642 MAIN ST.</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>GRACE</u> (Middle) <u>E</u> (Last) <u>FOX</u>				4. DATE OF DEATH (Month) <u>DEC</u> (Day) <u>11</u> (Year) <u>19 56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>7/20/1870</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>SAMUEL B. YINGLING</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE WILLIAMS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Frank L. Smith, Jr.</u> <u>Cockeysville, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>Anterio-Septic Cardis Vascula Disease</u>						<u>5 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/9/47</u> , 19 <u>56</u> , to <u>12/10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/10</u> , 19 <u>56</u> , and that death occurred at <u>12:50 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Walter J. Kern</u>				ADDRESS (Street, city, town, state) <u>Cockeysville, Md</u>		DATE SIGNED <u>12/10/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-14-56</u>		NAME OF CEMETERY OR CREMATORY <u>Asbury W-E</u>		LOCATION (City, town, or county) (State) <u>Reisterstown</u>	
24. REC'D BY REGISTRAR DATE <u>DEC 14 1956</u>		REGISTRAR'S SIGNATURE <u>Frank Smith, Jr.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. L. Cack</u>		ADDRESS <u>1517 St Paul St.</u>	

CERTIFICATE OF DEATH

1956 DEC 14

1. DECEASED PERSON'S NAME: [REDACTED]

2. SEX: [REDACTED]

3. DATE OF BIRTH: [REDACTED]

4. PLACE OF BIRTH: [REDACTED]

5. OCCUPATION: [REDACTED]

6. DATE OF DEATH: [REDACTED]

7. PLACE OF DEATH: [REDACTED]

8. CAUSE OF DEATH: [REDACTED]

9. MEDICAL HISTORY: [REDACTED]

10. PHYSICIAN'S SIGNATURE: [REDACTED]

11. CORONER'S SIGNATURE: [REDACTED]

12. MANNER OF DEATH: [REDACTED]

13. PLACE OF INTERMENT: [REDACTED]

14. OTHER INFORMATION: [REDACTED]

15. DATE OF FILING: [REDACTED]

16. FILING OFFICE: [REDACTED]

17. REGISTRAR'S SIGNATURE: [REDACTED]

18. COUNTY: [REDACTED]

19. TOWN: [REDACTED]

20. STATE: [REDACTED]

21. DECEASED PERSON'S ADDRESS: [REDACTED]

22. DECEASED PERSON'S PHONE: [REDACTED]

23. DECEASED PERSON'S SOCIAL SECURITY: [REDACTED]

24. DECEASED PERSON'S MARRIAGE: [REDACTED]

25. DECEASED PERSON'S EDUCATION: [REDACTED]

26. DECEASED PERSON'S RELIGION: [REDACTED]

27. DECEASED PERSON'S RACE: [REDACTED]

28. DECEASED PERSON'S ETHNICITY: [REDACTED]

29. DECEASED PERSON'S SEXUAL ORIENTATION: [REDACTED]

30. DECEASED PERSON'S HEIGHT: [REDACTED]

31. DECEASED PERSON'S WEIGHT: [REDACTED]

32. DECEASED PERSON'S HAIR: [REDACTED]

33. DECEASED PERSON'S EYES: [REDACTED]

34. DECEASED PERSON'S SKIN: [REDACTED]

35. DECEASED PERSON'S BLOOD TYPE: [REDACTED]

36. DECEASED PERSON'S BLOOD GROUP: [REDACTED]

37. DECEASED PERSON'S BLOOD PHASE: [REDACTED]

38. DECEASED PERSON'S BLOOD PRESSURE: [REDACTED]

39. DECEASED PERSON'S BLOOD SUGAR: [REDACTED]

40. DECEASED PERSON'S BLOOD CHOLESTEROL: [REDACTED]

41. DECEASED PERSON'S BLOOD TRIGLYCERIDES: [REDACTED]

42. DECEASED PERSON'S BLOOD CREATININE: [REDACTED]

43. DECEASED PERSON'S BLOOD UREA NITROGEN: [REDACTED]

44. DECEASED PERSON'S BLOOD ALBUMIN: [REDACTED]

45. DECEASED PERSON'S BLOOD GLOBULIN: [REDACTED]

46. DECEASED PERSON'S BLOOD TOTAL PROTEIN: [REDACTED]

47. DECEASED PERSON'S BLOOD HEMOGLOBIN: [REDACTED]

48. DECEASED PERSON'S BLOOD HEMATOCRIT: [REDACTED]

49. DECEASED PERSON'S BLOOD RBC COUNT: [REDACTED]

50. DECEASED PERSON'S BLOOD WBC COUNT: [REDACTED]

51. DECEASED PERSON'S BLOOD PLATELET COUNT: [REDACTED]

52. DECEASED PERSON'S BLOOD FIBRINOGEN: [REDACTED]

53. DECEASED PERSON'S BLOOD PT/INR: [REDACTED]

54. DECEASED PERSON'S BLOOD APTT: [REDACTED]

55. DECEASED PERSON'S BLOOD TTP: [REDACTED]

56. DECEASED PERSON'S BLOOD D-DIMER: [REDACTED]

57. DECEASED PERSON'S BLOOD CRP: [REDACTED]

58. DECEASED PERSON'S BLOOD ESR: [REDACTED]

59. DECEASED PERSON'S BLOOD RF: [REDACTED]

60. DECEASED PERSON'S BLOOD ANA: [REDACTED]

61. DECEASED PERSON'S BLOOD ENA: [REDACTED]

62. DECEASED PERSON'S BLOOD ANCA: [REDACTED]

63. DECEASED PERSON'S BLOOD ASMA: [REDACTED]

64. DECEASED PERSON'S BLOOD ANCA: [REDACTED]

65. DECEASED PERSON'S BLOOD ANCA: [REDACTED]

66. DECEASED PERSON'S BLOOD ANCA: [REDACTED]

67. DECEASED PERSON'S BLOOD ANCA: [REDACTED]

68. DECEASED PERSON'S BLOOD ANCA: [REDACTED]

69. DECEASED PERSON'S BLOOD ANCA: [REDACTED]

70. DECEASED PERSON'S BLOOD ANCA: [REDACTED]

71. DECEASED PERSON'S BLOOD ANCA: [REDACTED]

72. DECEASED PERSON'S BLOOD ANCA: [REDACTED]

73. DECEASED PERSON'S BLOOD ANCA: [REDACTED]

74. DECEASED PERSON'S BLOOD ANCA: [REDACTED]

75. DECEASED PERSON'S BLOOD ANCA: [REDACTED]

76. DECEASED PERSON'S BLOOD ANCA: [REDACTED]

77. DECEASED PERSON'S BLOOD ANCA: [REDACTED]

78. DECEASED PERSON'S BLOOD ANCA: [REDACTED]

79. DECEASED PERSON'S BLOOD ANCA: [REDACTED]

80. DECEASED PERSON'S BLOOD ANCA: [REDACTED]

BUREAU V. S.

DEC 14 1956

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12138
 33
 Reg. Dist. No.

12166

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY 37064 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 131 Asqueth St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First CHARLES Middle FRANKLIN Last LI CHARLES FRANKLIN LI				4. DATE OF DEATH Month Dec Day 10 Year 1956											
5. SEX M. Colored		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 12. 1901		9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman				10b. KIND OF BUSINESS OR INDUSTRY Retired				11. BIRTHPLACE (State or foreign country) Wilmington, Va.				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Charles H. Franklin						14. MOTHER'S MAIDEN NAME Joanna ?									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Address Delores Franklin, 131 Asqueth St. Balto.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 hrs															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. None				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None											
20c. TIME OF INJURY Month, Day, Year Hour 5 a. m. Dec 10 p. m. 1956				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) Owings Mills Balto. Md		(County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.															
ACTUAL SIGNATURE D. D. Caples						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
EXAMINER'S NAME (Type) D. D. CAPLES, M.D.						DATE SIGNED Dec 10 '56									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/15/56		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.				22d. LOCATION (City, town, or county) (State) Balto. Md.					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Katie R. Williams 322 N. Schroder St.															
24a. REC'D BY REGISTRAR DATE 12-11-56						24b. REGISTRAR'S SIGNATURE Mary B. Eline.									

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

55

NAME OF DECEASED Charles E. Franklin		AGE 35		SEX Male		RACE Colored		DATE OF BIRTH Sept. 12, 1901		PLACE OF BIRTH Wilmington, Va.		DATE OF DEATH Dec 10, 1956		PLACE OF DEATH 131 Ashmun St., Baltimore	
CAUSE OF DEATH Homicide		MANNER OF DEATH Homicide		EDUCATION Grade 7		OCCUPATION None		RELIGION None		MARRIAGE None		SINGLE		MARRIED	
SIGNATURE OF MEDICAL EXAMINER Charles E. Franklin		SIGNATURE OF WITNESS None		SIGNATURE OF WITNESS None		SIGNATURE OF WITNESS None		SIGNATURE OF WITNESS None		SIGNATURE OF WITNESS None		SIGNATURE OF WITNESS None		SIGNATURE OF WITNESS None	

BUREAU V. S.

DEC 12 1956

RECEIVED

12/13/56
 131 Ashmun St., Baltimore, Md.
 131 Ashmun St., Baltimore, Md.

12167

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY in 1b <u>2 yrs.</u>				d. STREET ADDRESS <u>3630 Forest Garden Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3630 Forest Garden Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Pauline Friedlman</u>			4. DATE OF DEATH <u>Dec 18, 1956</u>			Year <u>19</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1888</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel Leiterman</u>				14. MOTHER'S MAIDEN NAME <u>Fannie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Benjamin Friedlman - Same</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic + Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 2, 1956</u> , to <u>Dec 18, 1956</u> , that I last saw the deceased alive on <u>Dec 18, 1956</u> , and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Manuel Levin</u> M.D.				ADDRESS (Street, city or town, state) <u>4818 Reisterstown Road</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>MANUEL LEVIN M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 19/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bnai Jacob Cong</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Levinson & Bros Inc</u> ADDRESS <u>1124-26 North Ave</u>				24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>Prochy Newell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 21 1956

RECEIVED

12168

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville				c. LENGTH OF STAY IN 1b 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3v01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 1606 Cherry Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Andrew Middle Garies Last (Garreis)				4. DATE OF DEATH Month December Day 7 Year 19 56			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, ?	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) brass finisher		10b. KIND OF BUSINESS OR INDUSTRY USCG --		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Peter Garies				14. MOTHER'S MAIDEN NAME Leona Strideberg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 420.1 DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome due to senile brain disease						INTERVAL BETWEEN ONSET AND DEATH a few days few years few years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 1, 1956 , to Dec. 7, 1956 , that I last saw the deceased alive on Dec. 7, 1956 , and that death occurred at 5:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 12-7-56							
ACTUAL SIGNATURE Bruno Radawski		PHYSICIAN'S NAME (Type) BRUNO RADAWSKI Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) B		22b. DATE THEREOF 12/11/56		22c. NAME OF CEMETERY OR CREMATORY Holy Cross		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes - 130 E. Fort Avenue				24a. REC'D BY REGISTRAR DATE DEC 10 '56		24b. REGISTRAR'S SIGNATURE Alfred	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director or page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		SEX Male		AGE 65		DATE OF BIRTH 1871	
RESIDENCE 1234 Main St., Baltimore, Md.		OCCUPATION Carpenter		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
DATE OF DEATH Dec 10, 1936		PLACE OF DEATH Home		SIGNATURE OF PHYSICIAN J. H. Smith, M.D.		SIGNATURE OF REGISTRAR J. H. Smith	
FATHER'S NAME John Harris		MOTHER'S NAME Mary Harris		EDUCATION High School		RELIGION Roman Catholic	
PREVIOUS ILLNESS None		PREVIOUS SURGERY None		PREVIOUS TRAUMA None		PREVIOUS TOXICITY None	
PREVIOUS ALCOHOLISM None		PREVIOUS DRUGS None		PREVIOUS TUBERCULOSIS None		PREVIOUS SYPHILIS None	
PREVIOUS DIABETES None		PREVIOUS GOUT None		PREVIOUS RHEUMATISM None		PREVIOUS EPILEPSY None	
PREVIOUS PARALYSIS None		PREVIOUS STROKE None		PREVIOUS ANEMIA None		PREVIOUS LEUKEMIA None	
PREVIOUS LYMPHOMA None		PREVIOUS SARCOMA None		PREVIOUS CARCINOMA None		PREVIOUS MALIGNANCY None	
PREVIOUS TUMORS None		PREVIOUS ABSCESS None		PREVIOUS EMPHYSEMA None		PREVIOUS BRONCHITIS None	
PREVIOUS PNEUMONIA None		PREVIOUS TUBERCULOSIS None		PREVIOUS SYPHILIS None		PREVIOUS GONORRHEA None	
PREVIOUS SYPHILIS None		PREVIOUS GONORRHEA None		PREVIOUS TUBERCULOSIS None		PREVIOUS PNEUMONIA None	
PREVIOUS BRONCHITIS None		PREVIOUS EMPHYSEMA None		PREVIOUS ABSCESS None		PREVIOUS TUMORS None	
PREVIOUS MALIGNANCY None		PREVIOUS CARCINOMA None		PREVIOUS SARCOMA None		PREVIOUS LYMPHOMA None	
PREVIOUS LEUKEMIA None		PREVIOUS ANEMIA None		PREVIOUS STROKE None		PREVIOUS PARALYSIS None	
PREVIOUS EPILEPSY None		PREVIOUS RHEUMATISM None		PREVIOUS GOUT None		PREVIOUS DIABETES None	
PREVIOUS DRUGS None		PREVIOUS ALCOHOLISM None		PREVIOUS TOXICITY None		PREVIOUS TRAUMA None	
PREVIOUS SURGERY None		PREVIOUS ILLNESS None		PREVIOUS DEATH None		PREVIOUS CAUSE None	

BUREAU V. S.

DEC 10 1936

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12142

12169

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 32 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 914 N. Eden Street Baltimore, Maryland			
f. STREET ADDRESS B 914 N. Eden Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle H. Last GARRETT				4. DATE OF DEATH Month December Day 18 Year 1956			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 23, 1875	
9. AGE (In years last birthday) yrs. 81		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Edgecomb Co., N. Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John Garrett				14. MOTHER'S MAIDEN NAME Delia Pare			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) P. I.				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UNDIAGNOSED TUMOR OF THE LUNGS, LYMPH NODES 239x PNEUMONIA AND BONE MARROW Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from November 16, 1956 , to December 18, 1956 , that I saw the deceased alive on December 18, 1956 , and that death occurred at 2:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VA HOSPITAL, FORT HOWARD, MARYLAND 12/19/56							
ACTUAL SIGNATURE C. J. Papastrat				M.D. VA HOSPITAL, FORT HOWARD, MARYLAND			
PHYSICIAN'S NAME (Type) C. J. PAPASTRAT, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/21/56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Low Mortuary, 802 N. Madison Ave. Balto. Md.				24a. REC'D BY REGISTRAR 12/22/56		24b. REGISTRAR'S SIGNATURE Dawson L. Macfar	

BUREAU V. S.

DEC 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12143

12170

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgeway Manor, 5743 Edmondson Ave.</u>		d. STREET ADDRESS <u>4406 Adelle Terrace</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Susanna</u> Last <u>Gaveghen</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 10, 1866</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>O.N.</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John P. Horn</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Mrs Fred Bremmer, 4406 Adelle Terrace</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Thrombosis, Coronary</u> DUE TO <u>Arteriosclerotic Cardiovascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thrombosis, Cerebral</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 15, 1956</u> to <u>Dec. 16, 1956</u> , that I last saw the deceased alive on <u>Dec. 15, 1956</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John F. Schaefer</u> M.D.		ADDRESS (Street, city or town, state) <u>401 Randolph Road</u> DATE SIGNED <u>Dec. 18, 1956</u>	
PHYSICIAN'S NAME (Type) <u>JOHN F. SCHAEFER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 19/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. White</u> ADDRESS <u>4101 Edmondson Ave</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 20 1956</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST		HEART DISEASE		SUICIDE		10-11		YES	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S MARRIAGE		MOTHER'S MARRIAGE	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

RECEIVED

DEC 20 1956

BUREAU A. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12144

12171

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>5604 Bland Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>ELSTIE</u> Middle <u>J.</u> Last <u>Also: MCGEE GLOVER</u>				4. DATE OF DEATH Month <u>December</u> Day <u>16</u> Year <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/1/12</u>	9. AGE (In years lost birthday) <u>44</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Winton, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William E. McGee</u>				14. MOTHER'S MAIDEN NAME <u>Pearl Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW-II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>CLIN. REC. VET. ADM. HOSP. FT. HOWARD, MARYLAND</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE LEFT BREAST WITH METASTASES</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>JAUNDICE DUE TO METASTASES TO LIVER</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>December 8</u> , 19 <u>56</u> , to <u>December 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>December 15</u> , 19 <u>56</u> , and that death occurred at <u>3:55 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>VAH, Fort Howard, Md.</u> DATE SIGNED <u>12/16/56</u> ACTUAL SIGNATURE <u>C. J. Papastrat M.D.</u> M.D. <u>VAH, Fort Howard, Maryland</u> PHYSICIAN'S NAME (Type) <u>C. J. PAPASTRAT, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>12-17-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) <u>Bristol, Tenn.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight Inc.</u>				24a. REC'D BY REGISTRAR DATE <u>12/17/56</u>		24b. REGISTRAR'S SIGNATURE <u>Jameson H. H. H.</u>	

Shipped to: Akard Funeral Home West State St. Bristol, Tenn.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12172

CERTIFICATE OF DEATH

12145
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore,</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Arbutus</u>		c. LENGTH OF STAY IN 1b <u>2Months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Locust Avenue</u>		d. STREET ADDRESS <u>Hopkins Apts-St. Paul & 31st Sts.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Selma</u> Last <u>Gocking</u>		4. DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1876</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>29</u> Hours <u>1</u> Min. <u>4</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleswoman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Silk</u>	
11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Anthony J. Gocking</u>		14. MOTHER'S MAIDEN NAME <u>Jennie ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>Mr. A. Norwood Funk</u>		Address <u>4702 Keswick Road.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, Cerebral</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>8/16</u> , 19 <u>56</u> , to <u>12/3/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/19</u> , 19 <u>56</u> , and that death occurred at <u>2:45</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Cliff Rathiff, Jr.</u> M.D. <u>4605 Edmondson ave</u> PHYSICIAN'S NAME (Type) <u>CLIFF RATHIFF, JR.</u> <u>4605 EDMONDSON AVE.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/5/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u>		ADDRESS <u>3000 E. Baltimore St.-24.</u>	
24a. REC'D BY REGISTRAR <u>DEC 6 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Geo. M. Kupper</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 9 1956

RECEIVED

12173

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 6 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in Pines 16 Fusting Ave.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Abraham Middle John Last Good				4. DATE OF DEATH Month Dec. Day 4 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 23, 1869	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Contractor			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Good			14. MOTHER'S MAIDEN NAME Mary Beasley				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Mildred F. Abel 3804 Milford Ave.,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Deorganization DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chr. Hypertens. Cardio Vascular Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 5 da. 20 yrs. (4)
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-30 , 1956 , to 12-4 , 1956 , that I last saw the deceased alive on 12-4 , 1956 , and that death occurred at 6:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6209 Frederick Ave. DATE SIGNED 12/6/56 ACTUAL SIGNATURE Wilmer K. Gallagher M.D. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher Balt. 28, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-7-1956		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Howard Strong ADDRESS 3707 W. North Ave				24a. REC'D BY REGISTRAR DEC 7 '56		24b. REGISTRAR'S SIGNATURE W. F. Edlich	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG209 1-11-57 et

12174

CERTIFICATE OF DEATH

12147

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yr-1mth5dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air, Maryland		12-32-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 101 North Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Catherine Gilbert Graef				4. DATE OF DEATH Month December Day 27 Year 19 56			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1870?		9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Gilbert				14. MOTHER'S MAIDEN NAME Beulah Gilbert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized and severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 22, 19 54 , to Dec. 27, 19 56 , that I last saw the deceased alive on Dec. 27, 19 56 , and that death occurred at 5:05a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachslar M.D. SPRING GROVE STATE HOSPITAL 12-27-56							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-31-56		22c. NAME OF CEMETERY OR CREMATORY Arceumount		22d. LOCATION (City, town, or county) (State) Philadelphia PA.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook				ADDRESS 1217 St. Paul St. Baltimore		24a. REC'D BY REGISTRAR DATE DEC 31 '56	
				24b. REGISTRAR'S SIGNATURE W. Beach			

CERTIFICATE OF DEATH

DEC 5 1911

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12148.4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTPOINT (24)		c. LENGTH OF STAY IN 1b 6 mo		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTPOINT — BALTO. CO. 24			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7953 LANSDALE RD.				d. STREET ADDRESS 7953 LANSDALE, RD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ANDREW JOSEPH GRAMOLA				4. DATE OF DEATH Month Day Year 12-24-1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 9, 1915	9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY WELDING SHOP		11. BIRTHPLACE (State or foreign country) N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH GRAMOLO				14. MOTHER'S MAIDEN NAME OSANNA CORRADI			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES. ✓ WW II		16. SOCIAL SECURITY NO. 050-01-8624		17. INFORMANT Address FLAMINGO ROSSI — DUNDALK, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 30 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack C. Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JACK C. COLLINS				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-28-56		22c. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL		22d. LOCATION (City, lawn, or county) (State) BALTO. MD	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Dundalk, Md.				24a. REC'D BY REGISTRAR DATE DEC 28 1956		24b. REGISTRAR'S SIGNATURE Lawrence S. Harker	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint handwritten text]		SEX [Faint handwritten text]		AGE [Faint handwritten text]	
RACE [Faint handwritten text]		OCCUPATION [Faint handwritten text]		PLACE OF BIRTH [Faint handwritten text]	
DATE OF DEATH [Faint handwritten text]		TIME OF DEATH [Faint handwritten text]		PLACE OF DEATH [Faint handwritten text]	
CAUSE OF DEATH [Faint handwritten text]		MANNER OF DEATH [Faint handwritten text]		SIGNATURE OF EXAMINER [Faint handwritten text]	
SIGNATURE OF WITNESS [Faint handwritten text]		SIGNATURE OF WITNESS [Faint handwritten text]		SIGNATURE OF WITNESS [Faint handwritten text]	

RECEIVED
 BUREAU V. S.
 DEC 28 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12176

CERTIFICATE OF DEATH

12149

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 5yr11mth14dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS (Warren's Hospital)			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First William Middle F. Last Green				4. DATE OF DEATH Month December Day 31 Year 19 56			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1883		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farming		10b. KIND OF BUSINESS OR INDUSTRY State Roads		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized and severe DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 5 , 19 56 , to Dec. 31 , 19 56 , that I last saw the deceased alive on Dec. 31 , 19 56 , and that death occurred at 4 P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslor		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL 12-31-56 DATE SIGNED					
PHYSICIAN'S NAME (Type) Stella Wachslor, M. D.		Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF January 3, 1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Dr. Willard Hamilton				24a. REC'D BY REGISTRAR Jan 5 1957		24b. REGISTRAR'S SIGNATURE W. H. ...	

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12177

CERTIFICATE OF DEATH

121502
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1312 Sudale Ave</u>				d. STREET ADDRESS <u>6517 Lehnert St</u>			
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>M.</u> Last <u>Gunning</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>16</u> Year <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 29 1901</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interior Decorator</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Berger Geblein</u>		11. BIRTHPLACE (State or foreign country) <u>Brooklyn N.Y.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-18-1632</u>		17. INFORMANT <u>William R. Gunning</u> Address <u>6517 Lehnert St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ca of stomach with metastasis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>4-6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY a. p. _____ p. m. <u>19</u>	Month, _____	Day, _____	Year _____	20d. INJURY OCCURRED While _____ Not while _____ at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>7</u> _____, 19 <u>56</u> to <u>12/16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/12</u> , 19 <u>56</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Milton Schleroff</u> M.D. _____							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 19 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nancy Amacos</u>				ADDRESS <u>4204 Ridgewood Ave</u>		24a. REC'D BY REGISTRAR DATE <u>12/17/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dorothy Howell</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. PLACE OF DEATH		7. TIME OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
JAMES H. HARRIS		M		45		W		12-17-56		BALTIMORE, MD		10:30 PM		HEART DISEASE		NATURAL		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
13. PLACE OF BIRTH		14. DATE OF BIRTH		15. PLACE OF BIRTH		16. DATE OF BIRTH		17. PLACE OF BIRTH		18. DATE OF BIRTH		19. PLACE OF BIRTH		20. DATE OF BIRTH		21. PLACE OF BIRTH		22. DATE OF BIRTH		23. PLACE OF BIRTH		24. DATE OF BIRTH	
BALTIMORE, MD		12-17-56		BALTIMORE, MD		12-17-56		BALTIMORE, MD		12-17-56		BALTIMORE, MD		12-17-56		BALTIMORE, MD		12-17-56		BALTIMORE, MD		12-17-56	
25. PLACE OF BIRTH		26. DATE OF BIRTH		27. PLACE OF BIRTH		28. DATE OF BIRTH		29. PLACE OF BIRTH		30. DATE OF BIRTH		31. PLACE OF BIRTH		32. DATE OF BIRTH		33. PLACE OF BIRTH		34. DATE OF BIRTH		35. PLACE OF BIRTH		36. DATE OF BIRTH	
BALTIMORE, MD		12-17-56		BALTIMORE, MD		12-17-56		BALTIMORE, MD		12-17-56		BALTIMORE, MD		12-17-56		BALTIMORE, MD		12-17-56		BALTIMORE, MD		12-17-56	

BUREAU V. 2

DEC 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12178

CERTIFICATE OF DEATH

12151 38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b <u>18 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>323 Murdoch Road</u>				d. STREET ADDRESS <u>323 Murdoch Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>B.</u> Last <u>HALL</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 4, 1860</u>	
9. AGE (In years last birthday) <u>96 yrs.</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nail Road Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Robert Hall</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mr. Frederick C. Hall</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerosis - generalized</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>acute left ventricular failure & pulmonary edema</u> DUE TO <u>edema</u> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs.</u> <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1953</u> , 19____, to <u>12/13/56</u> , 19____, that I last saw the deceased alive on <u>12/14/56</u> , 19____, and that death occurred at <u>12:30 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Francis W. Gluck</u> M.D.				ADDRESS (Street, city or town, state) <u>100 W University Pkwy</u> DATE SIGNED <u>12/14/56</u>			
PHYSICIAN'S NAME (Type) <u>Francis W. Gluck</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 15, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Sons Co.</u>				ADDRESS <u>4905 York Road</u>		24a. REC'D BY REGISTRAR <u>DATE 17 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Malcolm Gray</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. DATE OF DEATH	
3. COUNTY OF DEATH		4. CITY OR TOWN OF DEATH	
5. STREET OF DEATH		6. HOUSE NO.	
7. NAME OF DECEASED		8. SEX	
9. AGE		10. OCCUPATION	
11. MARITAL STATUS		12. CAUSE OF DEATH	
13. DATE OF BIRTH		14. PLACE OF BIRTH	
15. NAME OF FATHER		16. NAME OF MOTHER	
17. NAME OF SPOUSE		18. NAME OF CHILDREN	
19. NAME OF NEXT OF KIN		20. NAME OF PHYSICIAN	
21. NAME OF BURIAL PLACE		22. NAME OF CEMETERY	
23. NAME OF MINISTER		24. NAME OF CHURCH	
25. NAME OF FUNERAL HOME		26. NAME OF COFFIN	
27. NAME OF CASK		28. NAME OF CASK	
29. NAME OF CASK		30. NAME OF CASK	
31. NAME OF CASK		32. NAME OF CASK	
33. NAME OF CASK		34. NAME OF CASK	
35. NAME OF CASK		36. NAME OF CASK	
37. NAME OF CASK		38. NAME OF CASK	
39. NAME OF CASK		40. NAME OF CASK	
41. NAME OF CASK		42. NAME OF CASK	
43. NAME OF CASK		44. NAME OF CASK	
45. NAME OF CASK		46. NAME OF CASK	
47. NAME OF CASK		48. NAME OF CASK	
49. NAME OF CASK		50. NAME OF CASK	
51. NAME OF CASK		52. NAME OF CASK	
53. NAME OF CASK		54. NAME OF CASK	
55. NAME OF CASK		56. NAME OF CASK	
57. NAME OF CASK		58. NAME OF CASK	
59. NAME OF CASK		60. NAME OF CASK	
61. NAME OF CASK		62. NAME OF CASK	
63. NAME OF CASK		64. NAME OF CASK	
65. NAME OF CASK		66. NAME OF CASK	
67. NAME OF CASK		68. NAME OF CASK	
69. NAME OF CASK		70. NAME OF CASK	
71. NAME OF CASK		72. NAME OF CASK	
73. NAME OF CASK		74. NAME OF CASK	
75. NAME OF CASK		76. NAME OF CASK	
77. NAME OF CASK		78. NAME OF CASK	
79. NAME OF CASK		80. NAME OF CASK	
81. NAME OF CASK		82. NAME OF CASK	
83. NAME OF CASK		84. NAME OF CASK	
85. NAME OF CASK		86. NAME OF CASK	
87. NAME OF CASK		88. NAME OF CASK	
89. NAME OF CASK		90. NAME OF CASK	
91. NAME OF CASK		92. NAME OF CASK	
93. NAME OF CASK		94. NAME OF CASK	
95. NAME OF CASK		96. NAME OF CASK	
97. NAME OF CASK		98. NAME OF CASK	
99. NAME OF CASK		100. NAME OF CASK	

BUREAU V. 8

DEC 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12152

Reg. Dist. No.

12179

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Cockeysville</u>		c. LENGTH OF STAY IN 1b <u>3 Hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		3401.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Aircraft Armament - YAKB</u>				d. STREET ADDRESS <u>3004 Oakcrest Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William S</u> Middle <u>Harp</u> Last <u>Harp</u>				4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 20, 1896</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>60</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Burns Det. Agency</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Harp</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mrs. Henry Lindhorst, 9618 Harford Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cardio Renal Vascular Disease 1 yr.</u> (a), stating the underlying cause last. DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/24/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Road #14</u>			
24a. REC'D BY REGISTRAR <u>12/20/56</u>				24b. REGISTRAR'S SIGNATURE <u>Ann MacRae</u>			

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

RECEIVED

DEC 21 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-45 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

12153

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>Md.</u> COUNTY <u>Balto</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Timonium</u>		<u>20 mos</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Stella Maris Hospice</u>				STREET ADDRESS (If rural give location) <u>3600 Cedar Drive</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Lusie</u> (Middle) <u>Emma</u> (Last) <u>Hasbeek</u>				(Month) <u>12</u> (Day) <u>17</u> (Year) <u>19 56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>2-11-67</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homemaker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>John Edgar Summers</u>				14. MOTHER'S MAIDEN NAME <u>Mc Kenzie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unkn)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Leo Hasbeek - 3600 Cedar Drive</u>			
(If Yes, give war or dates of service)							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Intestinal Obstruction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>				20. YES <u>20</u> YES			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>with Myocardial Infarction</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>and Heart Block</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-22</u> , 19 <u>55</u> , to <u>12-15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-15</u> , 19 <u>56</u> , and that death occurred at <u>8:50</u> PM, from the causes and on the date stated above.							
SIGNATURE <u>Charles F. Donnell</u> M.D. <u>7501 York Rd - Elson</u> #4 Md <u>2/17/56</u>				ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/20/56</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Anna MacFarland</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Pickner & Sons - Balto.</u>		ADDRESS <u>Md.</u>	
DATE <u>12/20/56</u>							

CERTIFICATE OF DEATH

Form No. 10-54

ORIGINAL RECORDS OFFICE BY REGISTRATION

DATE OF DEATH

NAME OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

BUREAU V. 3

DEC 21 1956

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

12181

12154

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>rural--Owings Mills</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>rural--Owings Mills</u> STREET ADDRESS (If rural give location) <u>Garrison Forrest Rd.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>EDITH N. HENTZMAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>December 19 1956</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>8-30-1896</u>
9. AGE last birthday <u>60</u> yrs.		10. AGE last birthday IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Sankey Gartrell</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Pickett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS <u>Fred W. Hentzman, Same</u>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1 IMMEDIATE CAUSE (A) Coronary Thrombosis</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Arteriosclerotic CV. Disease</u> (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>5 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> Not white <input type="checkbox"/> et work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>48</u> , to <u>Dec. 19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 7</u> , 19 <u>56</u> , and that death occurred at <u>8:00p.</u> M, from the causes and on the date stated above. SIGNATURE <u>Morton E. Strobel</u> M.D. <u>48 Main St. Reisterstown, Md.</u> DATE SIGNED 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> DATE THEREOF <u>12-22-1956</u> NAME OF CEMETERY OR CREMATORY <u>Morgan Chapel</u> LOCATION (City, town, or county) (State) <u>Carroll Co. Md.</u>			
24. REC'D BY REGISTRAR <u>DEC 26 1956</u> DATE		25. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz, Winfield, Md.</u> ADDRESS	

CERTIFICATE OF DEATH

1. USUAL RESIDENCE OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. DATE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. PLACE OF BURIAL

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF JUDGE

19. SIGNATURE OF JURY

20. SIGNATURE OF JUDGE

21. SIGNATURE OF JURY

22. SIGNATURE OF JUDGE

23. SIGNATURE OF JURY

24. SIGNATURE OF JUDGE

25. SIGNATURE OF JURY

BUREAU V. 8

DEC 26 1956

RECEIVED

2100701717

DATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF DEATH

5. DATE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. PLACE OF BURIAL

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF JUDGE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12182

CERTIFICATE OF DEATH

12155

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> <u>52</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1430 Forest Park Ave.</u>				d. STREET ADDRESS <u>1430 Forest Park Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Edgar</u> Middle <u>C.</u> Last <u>Herpel</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>22</u> Year <u>19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1881</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Notions</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Conral Herpel</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Lintner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>--</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-12-9146</u>		17. INFORMANT Address <u>Mrs. Eva Gardener 1430 Forest Park Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Rectum</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>11/56</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/15</u> , 19 <u>56</u> , to <u>12/22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/15</u> , 19 <u>56</u> , and that death occurred at <u>8:10AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. J. McDevirmatt</u>				ADDRESS (Street, city or town, state) <u>524 Stanford Rd - 29</u> DATE SIGNED <u>12/22/56</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-24-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto.</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tracy Funeral Home - Catonsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 26 '56</u>		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1956

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		HISTORICAL DATA	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL OFFICIAL		SIGNATURE OF FUNERAL HOME		SIGNATURE OF OTHER	

BUREAU V. S.

DEC 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12183

CERTIFICATE OF DEATH

Reg. Dist. No.

12156 45

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rossville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rossville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 344 Phila. Rd.</u>				d. STREET ADDRESS <u>Box 344 Phila. Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>Marie</u> Last <u>HESS</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>9</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 26, 1876</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Karl Neubauer</u>				14. MOTHER'S MAIDEN NAME <u>Unknown Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Alice Hess Box 344 Phila. Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO (c) <u>2 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov 1</u> , 19 <u>56</u> , to <u>Dec 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 9</u> , 19 <u>56</u> , and that death occurred at <u>8:30 P. M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. M. Baumgardner</u> M.D.				ADDRESS (Street, city or town, state) <u>Balto 6 Md</u>			
PHYSICIAN'S NAME (Type) <u>G. M. Baumgardner</u>				DATE SIGNED <u>12/9/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 12, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Zion Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Golden Ring Rd. Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kassahn Funeral Home</u>				ADDRESS <u>7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 11 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED JAMES EARL RAY</p>		<p>2. SEX Male</p>	
<p>3. AGE 35</p>		<p>4. RACE White</p>	
<p>5. DATE OF BIRTH May 19, 1923</p>		<p>6. PLACE OF BIRTH Jackson, Mississippi</p>	
<p>7. DATE OF DEATH May 2, 1968</p>		<p>8. PLACE OF DEATH Memphis, Tennessee</p>	
<p>9. CAUSE OF DEATH Gunshot wound</p>		<p>10. MANNER OF DEATH Homicide</p>	
<p>11. SIGNATURE OF PHYSICIAN [Signature]</p>		<p>12. SIGNATURE OF REGISTRAR [Signature]</p>	

BUREAU V. 3

DEC 11 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12157

12184

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo. Co.</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood, Maryland</u> 16-34-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>3709 Tilden Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Olsen</u> Last <u>Horan</u>		4. DATE OF DEATH Month <u>December</u> Day <u>26</u> , 19 <u>56</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6, 1870</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Christian Olsen</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Gingle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <u>Diabetes mellitus</u> <u>Gangrene of right foot due to diabetes mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 9</u> , 19 <u>56</u> , to <u>Dec.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 26</u> , 19 <u>56</u> , and that death occurred at <u>8:45 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Stella Wachslar</u> M.D. <u>SPRING GROVE STATE HOSPITAL</u> <u>12-26-56</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u> <u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-29-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home Baltimore</u>		24a. REC'D BY REGISTRAR <u>W. J. Smith</u> DATE <u>Dec 31 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
MARRIAGE		RACE		EDUCATION		OCCUPATION		MANNER OF DEATH	
CAUSE OF DEATH		IMMEDIATE CAUSE		INTERMEDIATE CAUSE		UNDERLYING CAUSE		MANNER OF DEATH	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE		PULSE	
BLOOD PRESSURE		WEIGHT		HEIGHT		HAIR		EYES	
TEETH		TONGUE		THROAT		LUNGS		HEART	
LIVER		SPLEEN		PANCREAS		GASTRIC		INTESTINE	
BLADDER		RECTUM		VAGINA		UTERUS		OVARIES	
TESTES		PROSTATE		SEMINAL VESICLE		URETER		URETHRA	
SKIN		MUSCLES		BONES		JOINTS		SPINE	
HEAD		NECK		CHEST		ABDOMEN		PELVIS	
FEET		HANDS		FINGERS		TOES		NAILS	
TEETH		TONGUE		THROAT		LUNGS		HEART	
LIVER		SPLEEN		PANCREAS		GASTRIC		INTESTINE	
BLADDER		RECTUM		VAGINA		UTERUS		OVARIES	
TESTES		PROSTATE		SEMINAL VESICLE		URETER		URETHRA	
SKIN		MUSCLES		BONES		JOINTS		SPINE	
HEAD		NECK		CHEST		ABDOMEN		PELVIS	
FEET		HANDS		FINGERS		TOES		NAILS	

RECEIVED

DEC 31 1956

BUREAU V. S.

SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	
WITNESS NAME		WITNESS ADDRESS		WITNESS PHONE		WITNESS OCCUPATION		WITNESS RELATIONSHIP	
PHYSICIAN NAME		PHYSICIAN ADDRESS		PHYSICIAN PHONE		PHYSICIAN SPECIALTY		PHYSICIAN LICENSE NO.	
CORONER NAME		CORONER ADDRESS		CORONER PHONE		CORONER LICENSE NO.		CORONER RELATIONSHIP	
JURY NAME		JURY ADDRESS		JURY PHONE		JURY LICENSE NO.		JURY RELATIONSHIP	
DECEASED NAME		DECEASED ADDRESS		DECEASED PHONE		DECEASED OCCUPATION		DECEASED RELATIONSHIP	
DECEASED DATE OF BIRTH		DECEASED PLACE OF BIRTH		DECEASED RACE		DECEASED SEX		DECEASED AGE	
DECEASED MANNER OF DEATH		DECEASED CAUSE OF DEATH		DECEASED INTERMEDIATE CAUSE		DECEASED UNDERLYING CAUSE		DECEASED MANNER OF DEATH	
DECEASED DATE OF DEATH		DECEASED PLACE OF DEATH		DECEASED HOURS OF DEATH		DECEASED TEMPERATURE		DECEASED PULSE	
DECEASED BLOOD PRESSURE		DECEASED WEIGHT		DECEASED HEIGHT		DECEASED HAIR		DECEASED EYES	
DECEASED TEETH		DECEASED TONGUE		DECEASED THROAT		DECEASED LUNGS		DECEASED HEART	
DECEASED LIVER		DECEASED SPLEEN		DECEASED PANCREAS		DECEASED GASTRIC		DECEASED INTESTINE	
DECEASED BLADDER		DECEASED RECTUM		DECEASED VAGINA		DECEASED UTERUS		DECEASED OVARIES	
DECEASED TESTES		DECEASED PROSTATE		DECEASED SEMINAL VESICLE		DECEASED URETER		DECEASED URETHRA	
DECEASED SKIN		DECEASED MUSCLES		DECEASED BONES		DECEASED JOINTS		DECEASED SPINE	
DECEASED HEAD		DECEASED NECK		DECEASED CHEST		DECEASED ABDOMEN		DECEASED PELVIS	
DECEASED FEET		DECEASED HANDS		DECEASED FINGERS		DECEASED TOES		DECEASED NAILS	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

121583
Reg. Dist. No. 33

Item 4, Film G209, 1/7/57 fcy

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mantau Mill Road		d. STREET ADDRESS Falls Road	
3. NAME OF DECEASED (Type or print) First Theodore Middle R. Last Howard		4. DATE OF DEATH Month Dec. Day 27, Year 19 56	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1905
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor in stone Quarry		10b. KIND OF BUSINESS OR INDUSTRY Balto. City	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph S. Howard		14. MOTHER'S MAIDEN NAME Martha E. Diggs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-16-6485	
17. INFORMANT Warren H. Powell		Address Glyndon, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning 891.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) * DUE TO (c) * INTERVAL BETWEEN ONSET AND DEATH 3 days.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased sat in closed car & garage & motor running	
20c. TIME OF INJURY Month, Day, Year Hour a. m. Dec 26 1956 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Employers Garage		20f. (City or town) (County) (State) Glyndon Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .			
ACTUAL SIGNATURE D. D. Caples		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. CAPLES		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12-27-'56	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 29, 1956	
22c. NAME OF CEMETERY OR CREMATORY Gough Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons		ADDRESS Reisterstown, Md.	
24a. REC'D BY REGISTRAR DATE 12-29-56		24b. REGISTRAR'S SIGNATURE Mary B. Eling.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John S. Howard		45		Male		White		Jan. 2, 1957		Baltimore, Md.	
Residence		Occupation		Cause of Death		Manner of Death		Signature of Examiner		Signature of Coroner	
Baltimore, Md.		Police Officer		Heart Disease		Natural		J. L. Linn		J. L. Linn	
John S. Howard		45		Male		White		Jan. 2, 1957		Baltimore, Md.	
Baltimore, Md.		Police Officer		Heart Disease		Natural		J. L. Linn		J. L. Linn	

RECEIVED
JAN 2 1957
BUREAU A. 3

J. L. Linn & Sons, Baltimore, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12159

12186

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Stevensville</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>11 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>17X-2</u>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>H</u> Last <u>HOXTER</u>				4. DATE OF DEATH Month <u>December</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/6/97</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>59</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Stevensville, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Hoxter</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Cole</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW-II</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MARYLAND</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO <u>ARTERIOSCLEROSIS, GENERALIZED</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial infarctions, old & recent; Duodenal ulcer with perforation; Lower nephron nephrosis; Bronchitis, bilateral</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 Minute</u> <u>5 Years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>December 17, 1956</u> , to <u>December 28, 1956</u> , that I last saw the deceased alive on <u>December 28, 1956</u> , and that death occurred at <u>2:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Armen Bogosian</u>				ADDRESS (Street, city or town, state) <u>VAH, Fort Howard, Maryland</u>		DATE SIGNED <u>12/28/56</u>	
PHYSICIAN'S NAME (Type) <u>ARMEN BOGOSIAN, M.D.</u>				VAH, Fort Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 31</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Stevensville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Lane</u>				ADDRESS <u>Edgar Lane Funeral Home Church Hill, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>12/31/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Donald Fisher</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED

DEC 31 1956

BUREAU V. S.

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF DECEASED</p>		<p>14. SIGNATURE OF WITNESS</p>		<p>15. SIGNATURE OF PHYSICIAN</p>		<p>16. SIGNATURE OF CORONER</p>	
<p>17. SIGNATURE OF MINISTER OF THE GOSPEL</p>		<p>18. SIGNATURE OF CHURCH CLERK</p>		<p>19. SIGNATURE OF BURIAL PLACE</p>		<p>20. SIGNATURE OF FUNERAL HOME</p>	
<p>21. SIGNATURE OF MARRIAGE OFFICIAL</p>		<p>22. SIGNATURE OF JUDGE</p>		<p>23. SIGNATURE OF CLERK</p>		<p>24. SIGNATURE OF DEPUTY CLERK</p>	
<p>25. SIGNATURE OF ASSISTANT CLERK</p>		<p>26. SIGNATURE OF RECORDS SECTION</p>		<p>27. SIGNATURE OF STATISTICS SECTION</p>		<p>28. SIGNATURE OF INSPECTION SECTION</p>	
<p>29. SIGNATURE OF LABORATORY</p>		<p>30. SIGNATURE OF PATHOLOGY</p>		<p>31. SIGNATURE OF RADIOLOGY</p>		<p>32. SIGNATURE OF DENTISTRY</p>	
<p>33. SIGNATURE OF OPTOMETRY</p>		<p>34. SIGNATURE OF PODIATRY</p>		<p>35. SIGNATURE OF NURSING</p>		<p>36. SIGNATURE OF PHARMACY</p>	
<p>37. SIGNATURE OF VETERINARY</p>		<p>38. SIGNATURE OF AGRICULTURE</p>		<p>39. SIGNATURE OF FISHERIES</p>		<p>40. SIGNATURE OF FORESTRY</p>	
<p>41. SIGNATURE OF MINING</p>		<p>42. SIGNATURE OF MANUFACTURES</p>		<p>43. SIGNATURE OF COMMERCE</p>		<p>44. SIGNATURE OF TRANSPORTATION</p>	
<p>45. SIGNATURE OF EDUCATION</p>		<p>46. SIGNATURE OF HEALTH</p>		<p>47. SIGNATURE OF SOCIAL WELFARE</p>		<p>48. SIGNATURE OF LABOR</p>	
<p>49. SIGNATURE OF HOUSING</p>		<p>50. SIGNATURE OF PUBLIC WORKS</p>		<p>51. SIGNATURE OF UTILITIES</p>		<p>52. SIGNATURE OF FIRE</p>	
<p>53. SIGNATURE OF POLICE</p>		<p>54. SIGNATURE OF PROSECUTION</p>		<p>55. SIGNATURE OF JUDICIARY</p>		<p>56. SIGNATURE OF LEGISLATURE</p>	
<p>57. SIGNATURE OF EXECUTIVE</p>		<p>58. SIGNATURE OF GOVERNMENT</p>		<p>59. SIGNATURE OF STATE</p>		<p>60. SIGNATURE OF NATION</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12160

12187

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradshaw		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradshaw	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reynolds Rd.		d. STREET ADDRESS Reynolds Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sadye Middle E. Last Huber		4. DATE OF DEATH Month Dec. Day 13 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1883
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Kaufmann		14. MOTHER'S MAIDEN NAME Ella Derr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT John A. Huber		Address Reynolds Rd. Bradshaw, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Dis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture Rx. Hip 904.9		INTERVAL BETWEEN ONSET AND DEATH 36 hrs. 10 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/11 , 19 56 , to 12/13 , 19 56 that I last saw the deceased alive on 12/12 , 19 56 , and that death occurred at 12:15 PM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Fork, Md. DATE SIGNED 12/14/56	
ACTUAL SIGNATURE Clifford F. Hudson M.D.			
PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 15, 1956	22c. NAME OF CEMETERY OR CREMATORY Salem Methodist	22d. LOCATION (City, town, or county) (State) Bradshaw, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Louise Funeral Home ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR 17 1956 DATE	
		24b. REGISTRAR'S SIGNATURE Dr. Walter Hammett	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED ANTHONY J. JACOBSON</p>		<p>2. SEX MALE</p>	
<p>3. AGE 45</p>		<p>4. DATE OF BIRTH 1911</p>	
<p>5. PLACE OF BIRTH NEW YORK</p>		<p>6. OCCUPATION LABORER</p>	
<p>7. MARITAL STATUS MARRIED</p>		<p>8. DATE OF MARRIAGE 1935</p>	
<p>9. NAME OF SPOUSE JOHN J. JACOBSON</p>		<p>10. DATE OF DEATH 1956</p>	
<p>11. PLACE OF DEATH HOME</p>		<p>12. CAUSE OF DEATH ANTHROPIC DEATH</p>	
<p>13. MEDICAL HISTORY NO</p>		<p>14. SURVIVAL NO</p>	
<p>15. SIGNATURE OF DECEASED ANTHONY J. JACOBSON</p>		<p>16. SIGNATURE OF WITNESS JOHN J. JACOBSON</p>	
<p>17. SIGNATURE OF PHYSICIAN ANTHONY J. JACOBSON</p>		<p>18. SIGNATURE OF CORONER ANTHONY J. JACOBSON</p>	
<p>19. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>20. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>21. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>22. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>23. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>24. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>25. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>26. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>27. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>28. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>29. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>30. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>31. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>32. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>33. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>34. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>35. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>36. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>37. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>38. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>39. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>40. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>41. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>42. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>43. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>44. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>45. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>46. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>47. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>48. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>49. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>50. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>51. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>52. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>53. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>54. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>55. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>56. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>57. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>58. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>59. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>60. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>61. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>62. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>63. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>64. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>65. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>66. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>67. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>68. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>69. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>70. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>71. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>72. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>73. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>74. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>75. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>76. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>77. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>78. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>79. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>80. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>81. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>82. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>83. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>84. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>85. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>86. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>87. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>88. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>89. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>90. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>91. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>92. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>93. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>94. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>95. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>96. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>97. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>98. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	
<p>99. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>		<p>100. SIGNATURE OF JURY ANTHONY J. JACOBSON</p>	

BUREAU V. 3

DEC 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12161

Items 8,9: Film G208 12-31-56L

CERTIFICATE OF DEATH

Reg. Dist. No.

12188

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 7803 Oak Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Clinton M. Hunter		4. DATE OF DEATH Month Day Year Dec. 21 19 56	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1883 July 26 1877
9. AGE (In years last birthday) 73 7/9 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interior decorator		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Hunter		14. MOTHER'S MAIDEN NAME Laura Cloud	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Mary E. Hunter		Address as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO 241x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema + Bronchial Asthma DUE TO 10 yrs. (c)		INTERVAL BETWEEN ONSET AND DEATH 15 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic arthritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1938 to Dec. 21, 1956 that I last saw the deceased alive on Dec. 20, 1956 and that death occurred at 7:45 P. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. M. Bacon		ADDRESS (Street, city or town, state) 2810 Taylor Ave. Baltimore 14-Md.	
PHYSICIAN'S NAME (Type) A. M. BACON		DATE SIGNED Dec 26 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 24 1956	
22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William J. Zuckew + Sons		24a. REC'D BY REGISTRAR DEC 26 1956	
ADDRESS York + Penna Ave		24b. REGISTRAR'S SIGNATURE W. H. M. Bacon	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
JAMES H. HARRIS		M		45		JAN 15 1880		BALTIMORE, MD		LABORER	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANCE	
DEC 20 1933		BALTIMORE, MD		HEART DISEASE		SUICIDE		CORONARY ARTERY DISEASE		NONE	
TIME OF DEATH		HOURS		MINUTES		TEMPERATURE		PULSE		RESPIRATION	
10:00 PM		10		00		98.6		60		16	
NAME OF PHYSICIAN		NAME OF SURGEON		NAME OF PATHOLOGIST		NAME OF BACTERIOLOGIST		NAME OF ANATOMIST		NAME OF ENTOMOLOGIST	
DR. J. H. HARRIS		DR. J. H. HARRIS		DR. J. H. HARRIS		DR. J. H. HARRIS		DR. J. H. HARRIS		DR. J. H. HARRIS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF SURGEON		SIGNATURE OF PATHOLOGIST		SIGNATURE OF BACTERIOLOGIST		SIGNATURE OF ANATOMIST		SIGNATURE OF ENTOMOLOGIST	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
DEC 20 1933		DEC 20 1933		DEC 20 1933		DEC 20 1933		DEC 20 1933		DEC 20 1933	

BUREAU V. S.

DEC 20 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12162

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN lb Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 412 Lambeth Rd.		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md b. COUNTY Balto c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 412 Lambeth Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph John Huppmann		4. DATE OF DEATH Month December Day 7 Year 1986	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1910
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Treasurer		10b. KIND OF BUSINESS OR INDUSTRY St. Charles College	
11. BIRTHPLACE (State or foreign country) Balto. Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis J. Huppmann		14. MOTHER'S MAIDEN NAME Catherine Zell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-18-7205	
17. INFORMANT Paul Huppmann		Address 414 Lambeth Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) 420.1 (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 0 a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Geo. S.M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Geo. S.M. Kieffer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 10/86	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzle		ADDRESS 4101 E dmondson Av	
24a. REC'D BY REGISTRAR DEC 10 '86		24b. REGISTRAR'S SIGNATURE W. H. H.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12190

CERTIFICATE OF DEATH

Reg. Dist. No.

121639

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jacksonville</u>		c. LENGTH OF STAY IN 1b <u>6 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Madonna</u>		12-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>White Hall R.D.</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Katherine</u> First <u>May</u> Middle <u>Irwin</u> Last				4. DATE OF DEATH Month <u>Dec</u> Day <u>7</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 18 - 1898</u>	9. AGE (In years last birthday) yrs. <u>58</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Black & Decker</u>		11. BIRTHPLACE (State or foreign country) <u>Jarrettville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John P Schuster</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Hildt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-24-6879</u>		17. INFORMANT Address <u>Mrs George Holland Phoenix Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>199.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid arthritis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 16, 1956</u> , to <u>Dec 7, 1956</u> , that I last saw the deceased alive on <u>7th Dec., 1956</u> , and that death occurred at <u>10:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. K. Quinn</u> M.D.				ADDRESS (Street, city or town, state) <u>1927 York Rd.</u>		DATE SIGNED <u>12/8/56</u>	
PHYSICIAN'S NAME (Type) <u>M. KEVIN QUINN</u>				TIMONUIT Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 10, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel</u>		22d. LOCATION (City, town, or county) (State) <u>Madonna Hartford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marion S. Kutz</u>				ADDRESS <u>Santharella Rd</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 13 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Ely Gornick</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

The State of Maryland
 Dec 18 1938
 Bethel

RECEIVED
 DEC 18 1938

BUREAU V. 2

-The -
 210-24-2424 Jan 20-24-2424
 John P. Schuster
 Black & white photograph
 Female white
 Dec 18 - 1938
 Mary Schuster
 Dec 7 1938

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>80 Mellor Ave</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>	
3. NAME OF DECEASED (Type or print) <u>BRADLEY O. ISAAC</u>		4. DATE OF DEATH <u>12/17/56</u> 19 <u>56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/17/1874</u> 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Isaac</u>		14. MOTHER'S MAIDEN NAME <u>Leather</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Mr. Lucretia Isaac</u>	
17. INFORMANT <u>Mr. Lucretia Isaac</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebro Vascular Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arterio Sclerotic C-V. Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>15 yr+</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/30</u> , 19 <u>55</u> , to <u>12/17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/17</u> , 19 <u>56</u> , and that death occurred at <u>11:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Victor F. King</u> M.D.		ADDRESS (Street, city or town, state) <u>715 Frederick Ave Balto MD</u>	
PHYSICIAN'S NAME (Type) _____		DATE SIGNED <u>12/18/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/21/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Robinson</u> ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR DATE _____	
		24b. REGISTRAR'S SIGNATURE <u>Outman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12192 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Balto.	MARYLAND	STATE Md.	COUNTY Balto.
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 TOWN Catonsville	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR 52 TOWN Catonsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 165 Winters Ave.		STREET ADDRESS (If rural give location) 165 Winters Ave.	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
WILLIAM JOHNSON		Dec. 29, 1956	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
Male	Col.	Married	April 2, 1886
9. AGE last birthday		10. IF UNDER 1 YEAR Months Days Hours Min.	
70 yrs.		70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
Laborer			
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Howard Co. Md.		U. S. A.	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
William H. Johnson		Louise	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
No			
17. INFORMANT & ADDRESS:			
Eleanora Johnson 165 Winters Ave			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) Pneumonia			3 days
ANTECEDENT CAUSE (B) Coronary heart failure & chronic glomerulonephritis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 29 June 1956 to 29 Dec. , 19 56 , that I last saw the deceased alive on 28 Dec. , 19 56 , and that death occurred at 1215 P M, from the causes and on the date stated above.			
SIGNATURE C. R. Scudim		DATE SIGNED 25 Jan 57	
M. D. 3058 Winters Ave			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
Burial		West Liberty	
DATE REC'D BY LOCAL REGISTRAR Jan 2, 1957		REGISTRAR'S SIGNATURE U. W. Hedrich	
24. FUNERAL DIRECTOR		ADDRESS 224	
Mrs. Kate R. Williams		Schmiedt	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OFFICE OF THE SECRETARY OF THE ARMY

RECEIVED

NOV 1917

TO THE SECRETARY OF THE ARMY
FROM THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

12193

CERTIFICATE OF DEATH

12166

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5826 Westwood Ave.		d. STREET ADDRESS 5826 Westwood Ave.	
3. NAME OF DECEASED (Type or print) ELIZABETH A. JONES		4. DATE OF DEATH Month December Day 22 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1869
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John O'Connor		14. MOTHER'S MAIDEN NAME Annie Balster	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Eva Jones		Address 5826 Westwood Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Oedema 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardio-Vascular/Hypertensive Disease DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 1 day 8 years 8 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 19 48 , to Dec; 22 , 19 56 , that I last saw the deceased alive on Dec; 22 , 19 56 , and that death occurred at 6:45 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Michael J. Dausch M.D. 4636 Belair Road		ADDRESS (Street, city or town, state) DATE SIGNED 12/23/56	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 26, 1956	22c. NAME OF CEMETERY OR CREMATORY Parkwood	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		ADDRESS 2401 Belair Rd.	24a. REC'D BY REGISTRAR DATE DEC 27 1956
		24b. REGISTRAR'S SIGNATURE Mrs. H. L. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

DEC 2 1952

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12167

12194

CERTIFICATE OF DEATH

Reg. Dist. No.

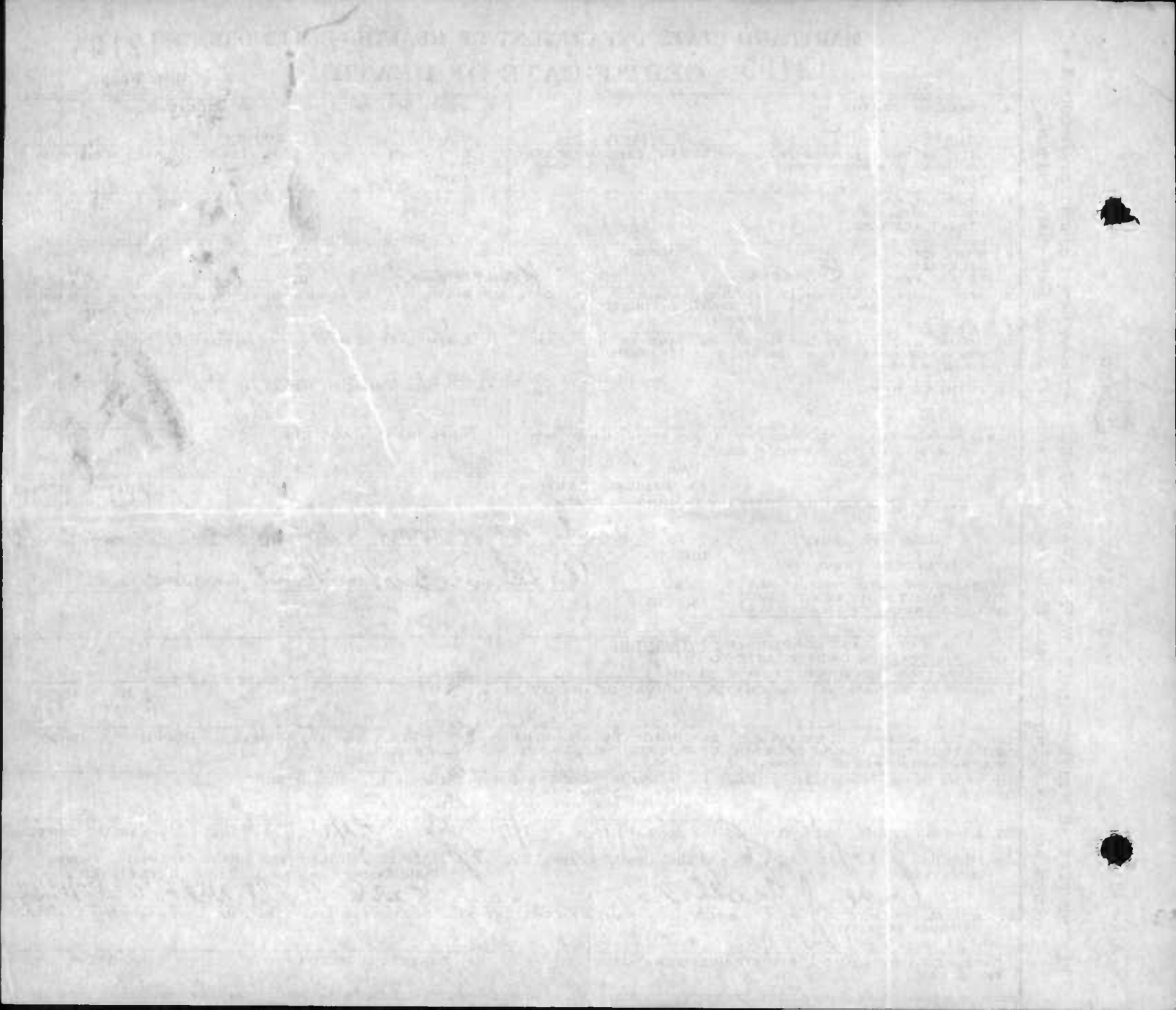
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Reside before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>36 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbackville</u> <u>83X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LAWSON</u> Middle <u>(NMI)</u> Last <u>JUSTICE</u>				4. DATE OF DEATH Month <u>December</u> Day <u>23</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/6/93</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Oyster House</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Justice</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Miles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWI</u>				16. SOCIAL SECURITY NO. <u>219-05-9083</u>		17. INFORMANT <u>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOGENIC CARCINOMA</u> DUE TO Circumstances, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>2-4 MONTHS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u> </u> m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>November 17, 1956</u> , to <u>December 23, 1956</u> , that I last saw the deceased alive on <u>December 12, 1956</u> , and that death occurred at <u>11:50 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>12/23/56</u> ACTUAL SIGNATURE <u>W. C. Dudley</u> M.D. <u>Veterans Administration Hospital</u> PHYSICIAN'S NAME (Type) <u>W. C. DUDLEY, M. D.</u> <u>Fort Howard, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-23-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Portersville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Stockton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WM COOK-BLIGHT</u>				ADDRESS <u>6009 HARFORD RD. BALTO</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12168
12195 CERTIFICATE OF DEATH Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>✓</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>BALTIMORE</u>	LENGTH OF STAY (in this place) <u>LIFE</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u> <u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 OAK HILL NURSING HOME</u>		STREET ADDRESS (If rural give location) <u>404 W. SARATOGA</u>	
3. NAME OF DECEASED: (Type or Print) <u>Emma</u> (First) (Middle) (Last) <u>Kaufman</u>		4. DATE OF DEATH: <u>DEC. 18</u> 19 <u>56</u> (Month) (Day) (Year)	
5. SEX: <u>FEMALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>JAN. 19, 1867</u> 89 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>
13. FATHER'S NAME: <u>JOHN</u>		14. MOTHER'S MAIDEN NAME: <u>JANE E. BALL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>NO</u>	16. SOCIAL SECURITY NO.: <u>220-07-4113</u>	17. INFORMANT & ADDRESS: <u>MRS. LILLIAN BRICKWEDGE GLENDALE HOSP. MD.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Acute myocardial Infarction</u>			<u>immediate</u>
ANTECEDENT CAUSE (S) (B) <u>Arteriosclerotic Heart Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>11/11</u> , 19 <u>56</u> , to <u>12/11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/15</u> , 19 <u>56</u> , and that death occurred at <u>4 p</u> M, from the causes and on the date stated above.			
SIGNATURE <u>W. J. Miller</u>		ADDRESS <u>5226 Balt N. Ave</u> DATE SIGNED <u>12/12/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>DEC. 20, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>DRUID RIDGE CEMETERY</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS <u>LAMBROS INC. 438-440 E. NORTH AVE</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12196

CERTIFICATE OF DEATH

12169

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>	
c. LENGTH OF STAY IN 1b <u>55 yrs.</u>		d. STREET ADDRESS <u>Oakland Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oakland Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Kerl</u>		4. DATE OF DEATH Month <u>December</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Febr. 6, 1870</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Marsh Run, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham Diffenderfer</u>		14. MOTHER'S MAIDEN NAME <u>Sybiella Trout</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Sybiella D. Kerl, Freeland, Md. R.D.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/6</u> , 19 <u>56</u> , to <u>12/6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/6</u> , 19 <u>56</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis Schatanoff</u> M.D.		ADDRESS (Street, city or town, state) <u>New Freedom, Pa.</u> DATE SIGNED <u>12/8/56</u>	
PHYSICIAN'S NAME (Type) <u>LOUIS SCHATANOFF, M.D.</u>		<u>New Freedom, Pa.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 8, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Shrewsbury Lutheran</u>	22d. LOCATION (City, town, or county) (State) <u>York Co., Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hertenstein</u> ADDRESS <u>New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>12/8/56</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>

CERTIFICATE OF DEATH

12101
38

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF REGISTRAR: [illegible]
DATE OF REGISTRATION: [illegible]

RECEIVED
DEC 11 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12197

CERTIFICATE OF DEATH

Reg. Dist. No.

121708

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b 6 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION TOWSON CONVALESCENT		d. STREET ADDRESS 1841 HARFORD ROAD	
3. NAME OF DECEASED (Type or print) First Middle Last Lena, E. D. Kirschke		4. DATE OF DEATH Month Day Year Dec. 28 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/6/72
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME WILLIAM HOERDER		14. MOTHER'S MAIDEN NAME ELIZABETH ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 219 01 5316	
17. INFORMANT 3501 ST PAUL STREET MR. CHARLES F. KIRSCHKE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-Sclerotic C-V disease. DUE TO (c) 15 yrs.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/19 , 19 53 , to 12/28 , 19 56 , that I last saw the deceased alive on 12/17 , 19 56 , and that death occurred at 10:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE For J. Schellack M.D. 200 W. Penna. Ave. Towson 12/28/56 PHYSICIAN'S NAME (Type) For J. S. E. L. F. C. K.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12/31/56	22c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY	22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND.
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS IN BALTIMORE MD.		24a. REC'D BY REGISTRAR DATE 2 1957	24b. REGISTRAR'S SIGNATURE Mabel King

RECEIVED

BUREAU V. S.

AN 2 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12198

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12171

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore-7			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore-7		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2 Gwynn Lake Drive			d. STREET ADDRESS 2 Gwynn Lake Drive		
3. NAME OF DECEASED (Type or print) First Doris Middle Mae Last Kittinger			4. DATE OF DEATH Month Dec. Day 23 Year 1966		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1924		9. AGE (In years last birthday) 31 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor-Opera-		10b. KIND OF BUSINESS OR INDUSTRY C&P Tel. Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Richard Kittinger			14. MOTHER'S MAIDEN NAME Annie L. Lloyd		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-14-8418		17. INFORMANT Mrs. Edw. Shaw., 6710 Chisholm Dr., Pikesv., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Decompensation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic C-V Disease DUE TO (c) none					INTERVAL BETWEEN ONSET AND DEATH 8-10 hrs. 31 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	
		20f. (City or town) none		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE D. D. Caples			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) D. D. Caples, M. D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-27-56		22c. NAME OF CEMETERY OR CREMATORY Woodlawn	
				22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. T. Stansbury, 6411 Windsor Mill Rd.			24a. REC'D BY REGISTRAR DEC 28 1956		
			24b. REGISTRAR'S SIGNATURE E. M. ...		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 19 1961

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 12199 CERTIFICATE OF DEATH

12172

Reg. Dist. No.

43

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton	c. LENGTH OF STAY IN 1b 38 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS 4201 Fullerton Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Helen First Middle Last W. Lassahn		4. DATE OF DEATH Month 12 Day 14 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/20/ 1892
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (State or foreign country) U.S.A. Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Misikofski	
14. MOTHER'S MAIDEN NAME Anna Bunk		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Walter E. Lassahn 4201 Fullerton Ave. 6	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 yr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April , 19 56 , to Dec. 14 , 19 56 , that I last saw the deceased alive on Dec. 7 , 19 56 , and that death occurred at 11 A . M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE William J. Fritz M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/17/56	22c. NAME OF CEMETERY OR CREMATORY Parkwood	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 7401 Belair Rd. 6		24a. REC'D BY REGISTRAR DATE DEC 17 1956 24b. REGISTRAR'S SIGNATURE Wm. A. L. Belknap	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12200

CERTIFICATE OF DEATH

1217331

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7,		c. LENGTH OF STAY IN 1b 3 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1906 Belmont Terrace		d. STREET ADDRESS 1906 Belmont Terrace	
3. NAME OF DECEASED (Type or print) First ERIC Middle LYNN Last LAWSON		4. DATE OF DEATH Month December Day 3, Year 1956.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 12, 1956.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) yrs. 21 Months 21 Days 21 Hours 21 Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Victor Ray Lawson		14. MOTHER'S MAIDEN NAME Ruby Winstead	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Victor R. Lawson		Address 1906 Belmont Terrace Baltimore 7, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute laryngo-tracheal bronchitis 500x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 2 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. s. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 11-27-56 , 19____, to 12-3-56 , 19____, that I last saw the deceased alive on 12-3-56 , 19____, and that death occurred at 7:10 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8204 Liberty Road, Balto 7, Md. DATE SIGNED _____ ACTUAL SIGNATURE Edwin L. Pierpont M.D. PHYSICIAN'S NAME (Type) E.L. Pierpont, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/5/56.	22c. NAME OF CEMETERY OR CREMATORY Good Shepherd Cemetery	22d. LOCATION (City, town, or county) (State) Ellicott City, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons, Catonsville 28 Md.		24a. REC'D BY REGISTRAR DEC 7 1956	24b. REGISTRAR'S SIGNATURE Dr. Jm. E. Martin

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		JANUARY 15, 1956		HOME	
AGE		SEX		RACE	
65		M		W	
MARRIED		OCCUPATION		EDUCATION	
YES		LABORER		8	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH	
JANUARY 15, 1956		BALTIMORE, MD.		BALTIMORE, MD.	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF INTERMENT	
HEART DISEASE		NATURAL		CATHOLIC CHURCH	
DETAILS OF CAUSE OF DEATH		DATE OF INTERMENT		NAME OF INTERMENT	
CORONARY THROMBOSIS		JANUARY 15, 1956		ST. ANNE'S CATHEDRAL	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
JANUARY 15, 1956		HOME		BALTIMORE, MD.	
NAME OF PHYSICIAN		NAME OF FUNERAL HOME		NAME OF BURIAL PLACE	
DR. JAMES H. HARRIS		JAMES H. HARRIS		ST. ANNE'S CATHEDRAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE	
[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JANUARY 15, 1956		JANUARY 15, 1956		JANUARY 15, 1956	

BUREAU V. 1

JAN 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12201

CERTIFICATE OF DEATH

12174

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>		d. STREET ADDRESS <u>1712 Bolton St</u>	
3. NAME OF DECEASED (Type or print) <u>Margaret Jaeger Leber</u> First Middle Last		4. DATE OF DEATH <u>Dec. 29</u> 19 <u>56</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16 1873</u> 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Glen Rock Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Henry Jaeger</u>		14. MOTHER'S MAIDEN NAME <u>MaryAnn Fuhrman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Henry H Leber</u> Address <u>4218 Kelway Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROSIS GENERALIZED</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>INDEF</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>54</u> , to <u>29 DEC</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>29 DEC</u> , 19 <u>56</u> , and that death occurred at <u>9:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. DeHoff</u> M.D.		ADDRESS (Street, city or town, state) <u>Loch Raven Shopping Center</u> DATE SIGNED <u>31 Dec 56</u>	
PHYSICIAN'S NAME (Type) <u>John B. DeHoff</u>		<u>Baltimore 12, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 2 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Douglas Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Jenkins</u>		ADDRESS <u>4905 York Rd</u>	
24a. REC'D BY REGISTRAR <u>Jan 2 57</u>		24b. REGISTRAR'S SIGNATURE <u>DeHoff</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		DATE OF DEATH	
AGE		SEX	
RACE		EDUCATION	
OCCUPATION		MARRIAGE	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF BIRTH		DATE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MEDICAL HISTORY	
PREVIOUS ILLNESS		TREATMENT	
FAMILY HISTORY		SOCIAL HISTORY	
SIGNS AND SYMPTOMS		LABORATORY TESTS	
PATHOLOGICAL FINDINGS		POST-MORTEM EXAMINATION	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		DATE	

BUREAU V. 2

JAN 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12175

12202

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 21 Hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS 167 South Morley Street	
3. NAME OF DECEASED (Type or print) First JAMES Middle V. Last LEGAMBI		4. DATE OF DEATH Month December Day 26 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1892
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Solicitor		10b. KIND OF BUSINESS OR INDUSTRY Newspaper	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Pietro Legambi		14. MOTHER'S MAIDEN NAME Carolina Vazzana	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 217-20-2425	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC DECOMPENSATION DUE TO 443 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROSIS, GENERALIZED - DURATION UNKNOWN		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 10:40 A.M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 7:40 A.M.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 25, 1956 to December 26, 1956 and that death occurred at 7:40 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE James J. Nolan		M.D. VA HOSPITAL, FORT HOWARD, MARYLAND 12/26/56	
PHYSICIAN'S NAME (Type) JAMES J. NOLAN, M.D., Acting Chief, Medical Service			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-29-56	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Frank Della Noce		ADDRESS 322 S. High St. Baltimore, Maryland	
24a. REC'D BY REGISTRAR DEC 27 1956		24b. REGISTRAR'S SIGNATURE James J. Nolan	

RECEIVED
DEC 28 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12203

CERTIFICATE OF DEATH

Reg. Dist. No.

12176

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pleasant Hill Road		d. STREET ADDRESS Pleasant Hill Road	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sadie Jane Lehnert		4. DATE OF DEATH Month Dec , Day 23 , Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 18, 1876
9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George V.N. Nice		14. MOTHER'S MAIDEN NAME Mary Sullivan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. M.L. Albrecht		Address 4610 Colburn Rd. Balto 29	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EMBOLUS 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC C.V. DISEASE WITH DUE TO (c) AURICULAR FIBRILLATION			INTERVAL BETWEEN ONSET AND DEATH 2 MIN. 10 YRS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X DIABETES MELLITUS			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1950 to DEC. 23, 1956 , that I last saw the deceased alive on DEC. 23, 1956 , and that death occurred at 3: P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Martin E. Stoeck		ADDRESS (Street, city or town, state) 48 Main St., Pikesville, Md.	
PHYSICIAN'S NAME (Type) Frank H. Newell		DATE SIGNED 12/24/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/26/56	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge	22d. LOCATION (City, town, or county) (State) Pikesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell		24a. REC'D BY REGISTRAR DEC 28 1956	
ADDRESS Pikesville, Md.		24b. REGISTRAR'S SIGNATURE Mary Elmer	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

12177

Reg. Dist. No.

12204

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALTIMORE</u>		LENGTH OF STAY (in this place) <u>2 weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>BALTIMORE County</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CATON Ridge Home</u>				STREET ADDRESS (If rural give location) <u>Ligon Rd. ELLICOTT CITY</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Edward A.</u> (Middle) <u>Leimbach</u> (Last)				(Month) <u>Dec. 18,</u> (Day) <u>19</u> (Year) <u>56</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>JAN. 29, 1880</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipping Clerk Ret. Store</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>BALTIMORE Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>August Leimbach</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>N</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Ligon Rd. ELLICOTT City, Md.</u> <u>Mrs. Geo. HARMENING</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Cardiac failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-sclerotic Cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1, 1955</u> , to <u>Dec. 18, 1956</u> , that I last saw the deceased alive on <u>Dec. 17, 1956</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Cliff Collett</u> M.D.				DATE SIGNED <u>12/19/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 21, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral Len</u>		LOCATION (City, town, or county) (State) <u>BALTO. MARYLAND</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>—</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>S. Truman Schuch</u>		ADDRESS <u>3512 Frederick Ave. (29)</u>	
DATE <u>DEC 23 56</u>							

CERTIFICATE OF DEATH

1956

Year of Birth

Place of Birth

Place of Death

Sex

Age

Occupation

Marital Status

Education

Religion

Usual Residence

Place of Death

Cause of Death

Immediate Cause

Intermediate Cause

Underlying Cause

Contributing Cause

Immediate Cause

Intermediate Cause

Contributing Cause

Immediate Cause

Intermediate Cause

Contributing Cause

Immediate Cause

Intermediate Cause

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BUREAU V. E.

DEC 26 1956

RECEIVED

INSTRUCTIONS

MARYLAND STATE DEPARTMENT OF HEALTH

12178

2411 N. Charles Street, Baltimore

12205 CERTIFICATE OF DEATH

Items 8,9 Film G208 12-27-56 et

Reg. Dist. No. 43

1. PLACE OF DEATH- COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Raspensburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Raspensburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>106 Kolb Ave</u>		STREET ADDRESS (If rural, give location) <u>106 Kolb Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>William</u>	(Middle) <u>J.</u>	(Last) <u>Heppert</u>
4. DATE OF DEATH	(Month) <u>Dec.</u>	(Day) <u>6</u>	(Year) <u>1956</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 10 1889</u>
9. AGE last birthday <u>70</u> yrs.		10. If under 1 year: Months <u>7</u> Days <u>10</u> Hours <u>71</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Rep.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Heppert</u>		14. MOTHER'S MAIDEN NAME <u>Sussang Dannermann</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		15. SOCIAL SECURITY No. <u></u>	
17. INFORMANT AND ADDRESS <u>Mary M. Heppert 106 Kolb Ave</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u>
420.1 Immediate cause (a) <u>acute coronary thrombosis</u>			
Antecedent cause(s) (b) _____			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 3 Sept, 1945, to 6 Dec, 1956, that I last saw the deceased alive on 5 DEC, 1956, and that death occurred at 8:45 a.m., from the causes and on the date stated above.

SIGNATURE Edward L. Holz M.D. 7425 Harford Rd. Balto 14 Th DATE SIGNED 6 Dec 56
(Degree or title) ADDRESS

23. BURIAL CREMATION REMOVAL (Specify) DATE NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)
Burial Dec 10-56 Holy Redeemer Cem Bdair Rd. Balto. 6 Md

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE M. FUNERAL DIRECTOR ADDRESS
Dec-9-1956 Mary T. Riegers Sippel Bros. 7110 Belair Rd

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Molz

7425 Harford Rd.

RECEIVED

DEC 20 1953

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12206

CERTIFICATE OF DEATH

12179

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 18 W. Preston Street	
3. NAME OF DECEASED (Type or print) FORREST R. LEWIS		4. DATE OF DEATH December 3 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1906
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR: Months 5 Days 10 Hours 5 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Ernest, Pennsylvania	
11. BIRTHPLACE (State or foreign country) U. S. A		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Luther Lewis		14. MOTHER'S MAIDEN NAME Sara Work	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) VW 11		16. SOCIAL SECURITY NO. 265-36-9191	
17. INFORMANT Clinical Records, Vet. Adm. Hospital, Ft. Howard Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE FROM ESOPHAGEAL VARICES 581.1 DUE TO LAENNEC'S CIRRHOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 10 Days 1 Yr. 5 MONTHS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 21, 1956 , to December 3, 1956 and that death occurred at 11:35 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Irving Freeman M.D.		DATE SIGNED 12/4/56	
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Acting Chief, Medical Service, VAH, Ft. Howard, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 12-4-56	22c. NAME OF CEMETERY OR CREMATORY Pine Groves Cemetery	22d. LOCATION (City, town, or county) (State) Rochester Mills, Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. ADDRESS 6009 Harford Rd., Balto., Md.		24a. REC'D BY REGISTRAR 12/11/56	24b. REGISTRAR'S SIGNATURE Lawson L. Farber

Shipped to: Robinson and Lythe Funeral Home, No. 7th St. Indiana, Pa.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. DATE OF BIRTH [REDACTED]</p>	
<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. OCCUPATION [REDACTED]</p>	
<p>7. MARITAL STATUS [REDACTED]</p>		<p>8. CAUSE OF DEATH [REDACTED]</p>	
<p>9. MEDICAL HISTORY [REDACTED]</p>		<p>10. DATE OF DEATH [REDACTED]</p>	
<p>11. PLACE OF DEATH [REDACTED]</p>		<p>12. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>13. SIGNATURE OF WITNESS [REDACTED]</p>		<p>14. SIGNATURE OF PHYSICIAN [REDACTED]</p>	
<p>15. SIGNATURE OF CORONER [REDACTED]</p>		<p>16. SIGNATURE OF JURY [REDACTED]</p>	
<p>17. SIGNATURE OF JURY [REDACTED]</p>		<p>18. SIGNATURE OF JURY [REDACTED]</p>	
<p>19. SIGNATURE OF JURY [REDACTED]</p>		<p>20. SIGNATURE OF JURY [REDACTED]</p>	
<p>21. SIGNATURE OF JURY [REDACTED]</p>		<p>22. SIGNATURE OF JURY [REDACTED]</p>	
<p>23. SIGNATURE OF JURY [REDACTED]</p>		<p>24. SIGNATURE OF JURY [REDACTED]</p>	
<p>25. SIGNATURE OF JURY [REDACTED]</p>		<p>26. SIGNATURE OF JURY [REDACTED]</p>	
<p>27. SIGNATURE OF JURY [REDACTED]</p>		<p>28. SIGNATURE OF JURY [REDACTED]</p>	
<p>29. SIGNATURE OF JURY [REDACTED]</p>		<p>30. SIGNATURE OF JURY [REDACTED]</p>	
<p>31. SIGNATURE OF JURY [REDACTED]</p>		<p>32. SIGNATURE OF JURY [REDACTED]</p>	
<p>33. SIGNATURE OF JURY [REDACTED]</p>		<p>34. SIGNATURE OF JURY [REDACTED]</p>	
<p>35. SIGNATURE OF JURY [REDACTED]</p>		<p>36. SIGNATURE OF JURY [REDACTED]</p>	
<p>37. SIGNATURE OF JURY [REDACTED]</p>		<p>38. SIGNATURE OF JURY [REDACTED]</p>	
<p>39. SIGNATURE OF JURY [REDACTED]</p>		<p>40. SIGNATURE OF JURY [REDACTED]</p>	
<p>41. SIGNATURE OF JURY [REDACTED]</p>		<p>42. SIGNATURE OF JURY [REDACTED]</p>	
<p>43. SIGNATURE OF JURY [REDACTED]</p>		<p>44. SIGNATURE OF JURY [REDACTED]</p>	
<p>45. SIGNATURE OF JURY [REDACTED]</p>		<p>46. SIGNATURE OF JURY [REDACTED]</p>	
<p>47. SIGNATURE OF JURY [REDACTED]</p>		<p>48. SIGNATURE OF JURY [REDACTED]</p>	
<p>49. SIGNATURE OF JURY [REDACTED]</p>		<p>50. SIGNATURE OF JURY [REDACTED]</p>	
<p>51. SIGNATURE OF JURY [REDACTED]</p>		<p>52. SIGNATURE OF JURY [REDACTED]</p>	
<p>53. SIGNATURE OF JURY [REDACTED]</p>		<p>54. SIGNATURE OF JURY [REDACTED]</p>	
<p>55. SIGNATURE OF JURY [REDACTED]</p>		<p>56. SIGNATURE OF JURY [REDACTED]</p>	
<p>57. SIGNATURE OF JURY [REDACTED]</p>		<p>58. SIGNATURE OF JURY [REDACTED]</p>	
<p>59. SIGNATURE OF JURY [REDACTED]</p>		<p>60. SIGNATURE OF JURY [REDACTED]</p>	
<p>61. SIGNATURE OF JURY [REDACTED]</p>		<p>62. SIGNATURE OF JURY [REDACTED]</p>	
<p>63. SIGNATURE OF JURY [REDACTED]</p>		<p>64. SIGNATURE OF JURY [REDACTED]</p>	
<p>65. SIGNATURE OF JURY [REDACTED]</p>		<p>66. SIGNATURE OF JURY [REDACTED]</p>	
<p>67. SIGNATURE OF JURY [REDACTED]</p>		<p>68. SIGNATURE OF JURY [REDACTED]</p>	
<p>69. SIGNATURE OF JURY [REDACTED]</p>		<p>70. SIGNATURE OF JURY [REDACTED]</p>	
<p>71. SIGNATURE OF JURY [REDACTED]</p>		<p>72. SIGNATURE OF JURY [REDACTED]</p>	
<p>73. SIGNATURE OF JURY [REDACTED]</p>		<p>74. SIGNATURE OF JURY [REDACTED]</p>	
<p>75. SIGNATURE OF JURY [REDACTED]</p>		<p>76. SIGNATURE OF JURY [REDACTED]</p>	
<p>77. SIGNATURE OF JURY [REDACTED]</p>		<p>78. SIGNATURE OF JURY [REDACTED]</p>	
<p>79. SIGNATURE OF JURY [REDACTED]</p>		<p>80. SIGNATURE OF JURY [REDACTED]</p>	
<p>81. SIGNATURE OF JURY [REDACTED]</p>		<p>82. SIGNATURE OF JURY [REDACTED]</p>	
<p>83. SIGNATURE OF JURY [REDACTED]</p>		<p>84. SIGNATURE OF JURY [REDACTED]</p>	
<p>85. SIGNATURE OF JURY [REDACTED]</p>		<p>86. SIGNATURE OF JURY [REDACTED]</p>	
<p>87. SIGNATURE OF JURY [REDACTED]</p>		<p>88. SIGNATURE OF JURY [REDACTED]</p>	
<p>89. SIGNATURE OF JURY [REDACTED]</p>		<p>90. SIGNATURE OF JURY [REDACTED]</p>	
<p>91. SIGNATURE OF JURY [REDACTED]</p>		<p>92. SIGNATURE OF JURY [REDACTED]</p>	
<p>93. SIGNATURE OF JURY [REDACTED]</p>		<p>94. SIGNATURE OF JURY [REDACTED]</p>	
<p>95. SIGNATURE OF JURY [REDACTED]</p>		<p>96. SIGNATURE OF JURY [REDACTED]</p>	
<p>97. SIGNATURE OF JURY [REDACTED]</p>		<p>98. SIGNATURE OF JURY [REDACTED]</p>	
<p>99. SIGNATURE OF JURY [REDACTED]</p>		<p>100. SIGNATURE OF JURY [REDACTED]</p>	

BUREAU V. S.

DEC 12 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12207 CERTIFICATE OF DEATH

12180
 Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN 1b <u>11 Days</u>				d. STREET ADDRESS <u>West Fayette & Paca Streets</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HERMAN</u> Middle <u>E.</u> Last <u>LIBSON</u>				4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>10/26/14</u>	
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>2</u> Hours <u>1</u> Min. <u>4</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ass't. Concession Mgr.</u>		11. BIRTHPLACE (State or foreign country) <u>Brooklyn, New York</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Theater</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Philip Libson</u>			
14. MOTHER'S MAIDEN NAME <u>Fannie Klein</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW-II</u>		16. SOCIAL SECURITY NO. <u>091 03 1690</u>		17. INFORMANT <u>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MARYLAND</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BACTERIAL SEPTICEMIA, STAPHYLOCOCCAL</u> DUE TO (c) <u>UNKNOWN</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 27, 1956</u> , to <u>December 8, 1956</u> , that I last saw the deceased alive on <u>December 7, 1956</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>VAH, Fort Howard, Md.</u>				DATE SIGNED <u>12/10/56</u>			
PHYSICIAN'S NAME (Type) <u>JAMES J. NOLAN, Chief, Medical Service VAH, Fort Howard, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>12-10-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Mount Carmel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Blight, Inc</u> ADDRESS <u>6009 Harford Road</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>12/11/56</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

DEC 12 1956

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12208

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>2 yrs</u>		d. STREET ADDRESS <u>717 Woodington Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge, 327 Harlem La.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>August</u> Middle <u>H. Lichtenberg</u> Last <u>Sr.</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>4</u> Year <u>19 56</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 7, 1878</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B & O R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>August H. Lichtenberg</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth M.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic Cardiovascular dis</u> <u>422.1</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia (Broncho), Epitheliomata of nose & face</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>July 20</u> , 19 <u>56</u> , to <u>Dec 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 4</u> , 19 <u>56</u> , and that death occurred at <u>12:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. Earl Pass, M.D.</u> M.D.		DATE SIGNED <u>Dec 29 1956</u>	
PHYSICIAN'S NAME (Type) <u>L. EARL PASS, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 7/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witzke</u>		24a. REC'D BY REGISTRAR <u>DEC 6 '56</u>	
ADDRESS <u>4101 Edmondson Ave</u>		24b. REGISTRAR'S SIGNATURE <u>Aw. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE OR INJURY	
AGE		SEX	
RACE		EDUCATION	
OCCUPATION		RELIGION	
MARITAL STATUS		DATE OF BIRTH	
PLACE OF BIRTH		DATE OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE OR INJURY	
AGE		SEX	
RACE		EDUCATION	
OCCUPATION		RELIGION	
MARITAL STATUS		DATE OF BIRTH	
PLACE OF BIRTH		DATE OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	

BUREAU V. S.

DEC 7 1956

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12182

12209

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) 9. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco - (Rural)</u>				c. LENGTH OF STAY IN 1b <u>3 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>GARROLL EDWARD - LONG</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9 - 1890</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plasterer</u>		11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Long</u>				14. MOTHER'S MAIDEN NAME <u>Martha Stamm</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-10-2469</u>		17. INFORMANT <u>Mrs C Edw Long, Hampstead</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Melanoma Base of Skull</u> DUE TO (b) <u>Melanoma malignant left chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>190X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>1 yr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/20</u> , 19 <u>54</u> , to <u>Dec 19</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Dec 18</u> , 19 <u>56</u> , and that death occurred at <u>1 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. N. Foard M.D.</u>		ADDRESS (Street, city or town, state) <u>23 North Main St Manchester, Md.</u>		DATE SIGNED <u>12/19/56</u>			
PHYSICIAN'S NAME (Type) <u>W. H. Foard M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-21-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>all Saints</u>		22d. LOCATION (City, town, or county) (State) <u>Reisterstown, Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E Tipton</u>		ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>DATE 12-19-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary B. Elmer</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
JAMES J. JONES		Male		35		White		Teacher	
6. PLACE OF BIRTH		7. PLACE OF DEATH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
Baltimore, Md.		Baltimore, Md.		Dec 20 1966		10:00 AM		Heart Disease	
11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED	
Natural		[Signature]		[Signature]		[Signature]		[Signature]	
16. PLACE OF BURIAL		17. NAME OF CEMETERY		18. NAME OF MINISTER		19. NAME OF CHURCH		20. NAME OF FUNERAL HOME	
Baltimore, Md.		Greenwood		Rev. J. A. Smith		St. Paul's		[Name]	

BUREAU V. 1

DEC 20 1966

RECEIVED

12210

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Philadelphia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 35 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 6046 Market Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First THOMAS Middle L. Last LONG				4. DATE OF DEATH Month December Day 28 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 16, 1895	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur				10b. KIND OF BUSINESS OR INDUSTRY Cab Co.		11. BIRTHPLACE (State or foreign country) New Brunswick, New Jersey	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Charles Long				14. MOTHER'S MAIDEN NAME Anna Mullin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. 184-09-8399		17. INFORMANT ClinCal Rec., Vet. Adm. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC BILATERAL PULMONARY TUBERCULOSIS DUE TO (c) UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 1. Pulmonary Emphysema, 2. Urinary Calculi, 3. Gastro-intestinal hemorrhage, 4. Arteriosclerotic Cardiovascular Disease.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from November 23, 1956 , to December 28, 1956 , and that death occurred at 6:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 12/28/56 ACTUAL SIGNATURE Aimen Bogosian M.D. VAH, FORT HOWARD, MARYLAND PHYSICIAN'S NAME (Type) AIMEN BOGOSIAN, M.D. VAH, Fort Howard, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12-29-56		22c. NAME OF CEMETERY OR CREMATORY Beverly National Cemetery		22d. LOCATION (City, town, or county) (State) Beverly, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc. Wm Cook-Blight, Inc., 6009 Harford Rd., Balto., Md.				24a. REC'D BY REGISTRAR 1957		24b. REGISTRAR'S SIGNATURE James L. Kahan	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12184

12211

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>18 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>1027 22nd St. N. W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>VANCIE</u> Middle <u>P</u> Last <u>LYON</u>				4. DATE OF DEATH Month <u>December</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/26/13</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Company</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Aaron Lyon</u>				14. MOTHER'S MAIDEN NAME <u>Emma Tharp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		(If yes, give war or dates of service) <u>WWII</u>		16. SOCIAL SECURITY NO. <u>577-10-5560</u>		17. INFORMANT <u>Clin. Rec. Vets. Admin. Hospital Ft. Howard, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF ESOPHAGUS</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. n. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 12, 1956</u> , to <u>December 30, 1956</u> , that I saw the deceased alive on <u>December 12, 1956</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Veterans Administration Hospital Fort Howard, Maryland</u> DATE SIGNED <u>12/31/56</u> ACTUAL SIGNATURE <u>James J. Nolan</u> M.D. <u> </u> PHYSICIAN'S NAME (Type) <u>JAMES J. NOLAN, Acting Chief, Medical Service</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>1/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Arlington, Virginia</u>		22d. LOCATION (City, town, or county) (State) <u>Ft. Myer, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHARLES P. LAW MORTUARY 802-OLMADISON AVE BALTO</u>				24a. REC'D BY REGISTRAR <u>Jan 4-56</u>		24b. REGISTRAR'S SIGNATURE <u>Howard Farber</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Shipped to Frazier's Funeral Home, 389 Rhode Island Ave. N.W. Washington, D.C.

BUREAU V. S.

JAN. 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1218738

12212

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carney	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9810 Maglidt Ave.		d. STREET ADDRESS 9810 Maglidt Ave.	
3. NAME OF DECEASED (Type or print) First Harry Middle H. Last Maglidt		4. DATE OF DEATH Month Dec. Day 5 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 30, 1875
9. AGE (In years last birthday) 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
11. BIRTHPLACE (State or foreign country) Balto. Co., Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry H. Maglidt		14. MOTHER'S MAIDEN NAME Susannah L. Perine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-05-4654	
17. INFORMANT Mrs. John H. Messner		Address 9810 Maglidt Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage with right hemiplegia DUE TO (b) Generalized arteriosclerosis with hypertension DUE TO (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 8, 1942 , to Dec 5, 1956 , that I last saw the deceased alive on Dec 5, 1956 , and that death occurred at 3:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. J. Alessi		ADDRESS (Street, city or town, State) 6217 Harford Rd Baltimore-14 Md	
PHYSICIAN'S NAME (Type) E. J. Alessi M.D.		DATE SIGNED 10/3/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 8, 1956	
22c. NAME OF CEMETERY OR CREMATORY St. John's Lutheran		22d. LOCATION (City, town, or county) (State) Harford Rd. Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		ADDRESS 7401 Belair Rd	
24a. REC'D BY REGISTRAR EC 10 1956		24b. REGISTRAR'S SIGNATURE Dr. R. M. Bacon	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES EARL RAY		M		35		W		1928		MEMPHIS, TENN		APR 4 1968		MEMPHIS, TENN		HEART DISEASE		NATURAL		JAMES EARL RAY		JAMES EARL RAY	
13. OCCUPATION		14. EDUCATION		15. MARITAL STATUS		16. RELIGION		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. S.

DEC 10 1955

RECEIVED

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed in 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

CERTIFICATE OF DEATH

12213

Reg. Dist. No. 42

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto Co</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL or end give nearest town) <u>Rosemont Rural</u>		LENGTH OF STAY (in this place) <u>32 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Balto.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>2844 Pa Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>Blana</u> (First) <u>J.</u> (Middle) <u>Marshall</u> (Last)				4. DATE OF DEATH (Month) <u>Dec</u> (Day) <u>3</u> (Year) <u>1936</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 15, 1877</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>do hom</u>		11. BIRTHPLACE (State or foreign country) <u>Medwin Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>	
13. FATHER'S NAME <u>Frank Buck</u>				14. MOTHER'S MAIDEN NAME <u>Florence Burrin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS <u>Richard J. Marshall 2844 Pa Ave</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) _____				Congestive heart failure			
ANTECEDENT CAUSE(S) DUE TO _____				Arteriosclerotic cardiovascular disease ? yrs.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO _____							
2605 _____ (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Diabetes mellitus</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6</u> 19 <u>34</u> , to <u>12/3</u> 19 <u>36</u> , that I last saw the deceased alive on <u>11/30</u> 19 <u>36</u> , and that death occurred at <u>1454</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Herbert J. Derickas</u>		M.D. <u>2436 Washington Blvd. Balto Md</u>		DATE SIGNED <u>12/3/36</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec 6, 1936</u>		NAME OF CEMETERY OR CREMATORY <u>Bedon Hill</u>		LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
24. REC'D BY REGISTRAR <u>Mr. Geo M. Luffey</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>A. K. Korman</u>		ADDRESS <u>Ext 140 S. Charles St</u>	
DATE <u>DEC 4 1936</u>							

CERTIFICATE OF DEATH

Form No. 10

1. DEATH OCCURRED

PLACE OF DEATH

DATE OF DEATH
TIME OF DEATH

NAME OF DECEASED
SEX
AGE

DATE OF BIRTH
PLACE OF BIRTH

DATE OF DEATH
TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

NAME OF DECEASED

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

BUREAU V. S.

DEC 4 1956

RECEIVED

RECEIVED

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

12114

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>105 5th Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>C.</u> Last <u>Martin</u>		4. DATE OF DEATH Month <u>December</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 25, 1945</u>
9. AGE (In years last birthday) <u>12</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>5</u> Hours <u>12</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Stockton, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George E. Martin</u>		14. MOTHER'S MAIDEN NAME <u>Lela Mae Sawyers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>George E. Martin</u>		Address <u>105 5th Ave. Lansdowne</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Bronchus</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Palsy.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>12 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 11, 1956</u> to <u>Dec. 5, 1956</u> , that I last saw the deceased alive on <u>Dec. 5, 1956</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Milton Siscovick M.D.</u> M.D.		ADDRESS (Street, city or town, state) <u>1429 W. Fayette St. Balto 23 Md.</u>	
PHYSICIAN'S NAME (Type) <u>Milton Siscovick M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-7-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>		ADDRESS <u>4107 Wilkens Avenue.</u>	
24a. REC'D BY REGISTRAR <u>DEC 10 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Geo. M. Kappeler</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 10 1956

BUREAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film G208 12-17-56 et

12190

12214

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 812 Register Ave.				c. LENGTH OF STAY IN 1b 3 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armaoost Nursing Home				d. STREET ADDRESS 1746 Park Ave.			
3. NAME OF DECEASED (Type or print) First Middle Last KATE BELL MC ALISTER				4. DATE OF DEATH December 5, 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 5, 1874	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home duties				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) S. C.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Dr. Benjamin Washington Bell				14. MOTHER'S MAIDEN NAME Elizabeth Bleckley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Hugh J. Hazelhurst				Address 1746 Park Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x CEREBRAL THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 10 YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12/1, 1956 to 12-5, 1956 that I last saw the deceased alive on 12-4, 1956, and that death occurred at 8:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Arthur Karfain M.D. 1532 Haverwood Rd 12-5-56 PHYSICIAN'S NAME (Type) ARTHUR KARFAIN M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 8, 1956		22c. NAME OF CEMETERY OR CREMATORY Ellmwood Cemetery		22d. LOCATION (City, town, or county) (State) Columbia, S. C.	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc. 1900 Eutaw Pl.				ADDRESS		24a. REC'D BY REGISTRAR DATE DEC 7 1956	
				24b. REGISTRAR'S SIGNATURE Mabel Gray			

CERTIFICATE OF DEATH

For Use by

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. DATE OF DEATH Dec 7 1956		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. SIGNATURE OF PHYSICIAN J. H. Harris	
10. SIGNATURE OF REGISTRAR J. H. Harris		11. SIGNATURE OF WITNESSES J. H. Harris		12. SIGNATURE OF DECEASED J. H. Harris	
13. SIGNATURE OF DECEASED J. H. Harris		14. SIGNATURE OF DECEASED J. H. Harris		15. SIGNATURE OF DECEASED J. H. Harris	
16. SIGNATURE OF DECEASED J. H. Harris		17. SIGNATURE OF DECEASED J. H. Harris		18. SIGNATURE OF DECEASED J. H. Harris	
19. SIGNATURE OF DECEASED J. H. Harris		20. SIGNATURE OF DECEASED J. H. Harris		21. SIGNATURE OF DECEASED J. H. Harris	
22. SIGNATURE OF DECEASED J. H. Harris		23. SIGNATURE OF DECEASED J. H. Harris		24. SIGNATURE OF DECEASED J. H. Harris	
25. SIGNATURE OF DECEASED J. H. Harris		26. SIGNATURE OF DECEASED J. H. Harris		27. SIGNATURE OF DECEASED J. H. Harris	
28. SIGNATURE OF DECEASED J. H. Harris		29. SIGNATURE OF DECEASED J. H. Harris		30. SIGNATURE OF DECEASED J. H. Harris	
31. SIGNATURE OF DECEASED J. H. Harris		32. SIGNATURE OF DECEASED J. H. Harris		33. SIGNATURE OF DECEASED J. H. Harris	
34. SIGNATURE OF DECEASED J. H. Harris		35. SIGNATURE OF DECEASED J. H. Harris		36. SIGNATURE OF DECEASED J. H. Harris	
37. SIGNATURE OF DECEASED J. H. Harris		38. SIGNATURE OF DECEASED J. H. Harris		39. SIGNATURE OF DECEASED J. H. Harris	
40. SIGNATURE OF DECEASED J. H. Harris		41. SIGNATURE OF DECEASED J. H. Harris		42. SIGNATURE OF DECEASED J. H. Harris	
43. SIGNATURE OF DECEASED J. H. Harris		44. SIGNATURE OF DECEASED J. H. Harris		45. SIGNATURE OF DECEASED J. H. Harris	
46. SIGNATURE OF DECEASED J. H. Harris		47. SIGNATURE OF DECEASED J. H. Harris		48. SIGNATURE OF DECEASED J. H. Harris	
49. SIGNATURE OF DECEASED J. H. Harris		50. SIGNATURE OF DECEASED J. H. Harris		51. SIGNATURE OF DECEASED J. H. Harris	
52. SIGNATURE OF DECEASED J. H. Harris		53. SIGNATURE OF DECEASED J. H. Harris		54. SIGNATURE OF DECEASED J. H. Harris	
55. SIGNATURE OF DECEASED J. H. Harris		56. SIGNATURE OF DECEASED J. H. Harris		57. SIGNATURE OF DECEASED J. H. Harris	
58. SIGNATURE OF DECEASED J. H. Harris		59. SIGNATURE OF DECEASED J. H. Harris		60. SIGNATURE OF DECEASED J. H. Harris	
61. SIGNATURE OF DECEASED J. H. Harris		62. SIGNATURE OF DECEASED J. H. Harris		63. SIGNATURE OF DECEASED J. H. Harris	
64. SIGNATURE OF DECEASED J. H. Harris		65. SIGNATURE OF DECEASED J. H. Harris		66. SIGNATURE OF DECEASED J. H. Harris	
67. SIGNATURE OF DECEASED J. H. Harris		68. SIGNATURE OF DECEASED J. H. Harris		69. SIGNATURE OF DECEASED J. H. Harris	
70. SIGNATURE OF DECEASED J. H. Harris		71. SIGNATURE OF DECEASED J. H. Harris		72. SIGNATURE OF DECEASED J. H. Harris	
73. SIGNATURE OF DECEASED J. H. Harris		74. SIGNATURE OF DECEASED J. H. Harris		75. SIGNATURE OF DECEASED J. H. Harris	
76. SIGNATURE OF DECEASED J. H. Harris		77. SIGNATURE OF DECEASED J. H. Harris		78. SIGNATURE OF DECEASED J. H. Harris	
79. SIGNATURE OF DECEASED J. H. Harris		80. SIGNATURE OF DECEASED J. H. Harris		81. SIGNATURE OF DECEASED J. H. Harris	
82. SIGNATURE OF DECEASED J. H. Harris		83. SIGNATURE OF DECEASED J. H. Harris		84. SIGNATURE OF DECEASED J. H. Harris	
85. SIGNATURE OF DECEASED J. H. Harris		86. SIGNATURE OF DECEASED J. H. Harris		87. SIGNATURE OF DECEASED J. H. Harris	
88. SIGNATURE OF DECEASED J. H. Harris		89. SIGNATURE OF DECEASED J. H. Harris		90. SIGNATURE OF DECEASED J. H. Harris	
91. SIGNATURE OF DECEASED J. H. Harris		92. SIGNATURE OF DECEASED J. H. Harris		93. SIGNATURE OF DECEASED J. H. Harris	
94. SIGNATURE OF DECEASED J. H. Harris		95. SIGNATURE OF DECEASED J. H. Harris		96. SIGNATURE OF DECEASED J. H. Harris	
97. SIGNATURE OF DECEASED J. H. Harris		98. SIGNATURE OF DECEASED J. H. Harris		99. SIGNATURE OF DECEASED J. H. Harris	
100. SIGNATURE OF DECEASED J. H. Harris		101. SIGNATURE OF DECEASED J. H. Harris		102. SIGNATURE OF DECEASED J. H. Harris	

BUREAU V. 1

DEC 7 1956

RECEIVED

12115

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1119 Raven Drive</u>		d. STREET ADDRESS <u>1119 Raven Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle <u>MONROE</u> Last <u>McCLELLAND</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>24</u> , Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> <u>married</u>	8. DATE OF BIRTH <u>Nov. 18, 1909</u>
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Arthur McClelland</u>		14. MOTHER'S MAIDEN NAME <u>Olive M. -</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Margaret G. McClelland - 1110 Raven Dr.</u>		Address <u>Halethorpe 27, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arthritis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs -</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1940</u> , to <u>12/24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/24</u> , 19 <u>56</u> , and that death occurred at <u>7 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas. L. Ball</u> M.D. <u>Smithicorn</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>12/24/56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/27/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Friendship, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Balto, Md</u>		24. REC'D BY REGISTRAR <u>Dr. East M. Kupper</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 15 1956	
AGE		SEX	
68		M	
RACE		EDUCATION	
W		H	
OCCUPATION		PLACE OF BIRTH	
C		M	
CAUSE OF DEATH		MANNER OF DEATH	
C		N	
IMMEDIATE CAUSE		FUNDAMENTAL CAUSE	
C		M	
MANNER OF DEATH		PLACE OF DEATH	
N		M	
DATE OF DEATH		PLACE OF DEATH	
JAN 15 1956		M	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. HARRIS		J. H. HARRIS	

BUREAU V. 2

DEC 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12192

12215 CERTIFICATE OF DEATH

Reg. Dist. No.

35

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>	
c. LENGTH OF STAY IN 1b <u>50 yrs.</u>		d. STREET ADDRESS <u>Beckleysville Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beckleysville Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bessie C. McCullough</u>		4. DATE OF DEATH <u>December 6, 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 10, 1895</u>
9. AGE (In years lost birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR <u>6</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Parkton Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Iruen McCullough</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Rosella Cole</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>George C. McCullough</u>		Address <u>Freeland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation</u> 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>frothy bronchial secretions</u> DUE TO (c) <u>Congestive heart failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Marked obesity</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>1:15</u> p. m. <u>Dec. 5, 1956</u>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 3, 1956</u> to <u>Dec. 5, 1956</u> , that I last saw the deceased alive on <u>Dec. 5, 1956</u> , and that death occurred at <u>11:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Robinson</u>		ADDRESS (Street, city or town, state) <u>New Freedom, Pa.</u>	
PHYSICIAN'S NAME (Type) <u>R. ROBINSON</u>		DATE SIGNED <u>12/8/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 10, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Parkton, Balt. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Kortenstein</u>		24. REC'D BY REGISTRAR <u>12/8/56</u>	
ADDRESS <u>New Freedom, Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Fulton</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED: *John W. Smith*

2. SEX: *Male*

3. AGE: *65*

4. DATE OF BIRTH: *Jan 15, 1891*

5. PLACE OF BIRTH: *St. Louis, Mo.*

6. OCCUPATION: *Teacher*

7. CAUSE OF DEATH: *Heart Disease*

8. PLACE OF DEATH: *Home*

9. DATE OF DEATH: *Dec 11, 1956*

10. SIGNATURE OF PHYSICIAN: *[Signature]*

11. SIGNATURE OF REGISTRAR: *[Signature]*

BUREAU V. 3

DEC 11 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, shall file it with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12193

12216 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>Rt #1 Box 153</u>			
3. NAME OF DECEASED (Type or print) First <u>JERRY</u> Middle <u>B.</u> Last <u>McPHERSON</u>				4. DATE OF DEATH Month <u>December</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/25/80</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>Bluffs, Ill.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Bluffs, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George McPherson</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth MN: Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW-I</u>				16. SOCIAL SECURITY NO. <u>220 09 6562</u>		17. INFORMANT <u>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MARYLAND</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART F. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMPHYSEMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease. Carcinomatosis pending microscopic examination: Diverticulosis of large bowel.</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>November 1</u> , 19 <u>56</u> , to <u>December 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>November 15</u> , 19 <u>56</u> , and that death occurred at <u>11:55 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. J. Papastrat M.D.</u>				ADDRESS (Street, city or town, state) <u>VAH, Fort Howard, Md.</u> DATE SIGNED <u>12/16/56</u>			
PHYSICIAN'S NAME (Type) <u>C. J. PAPA STRAT, M.D.</u>				VAH, Fort Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-19-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Fort Belvoir, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Taylor & Son Funeral Home Annapolis, Maryland</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>U. Brumel</u>	
24b. REGISTRAR'S SIGNATURE <u>U. Brumel</u>				DATE <u>12/17/56</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Form 10-56

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]		RACE [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		PLACE OF INTERMENT [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF WITNESS [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF NEXT OF KIN [Illegible]		SIGNATURE OF BURIAL SOCIETY [Illegible]	

BUREAU V. B.

DEC 21 1956

RECEIVED

THIS CERTIFICATE IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH. IT IS LOANED TO YOU FOR YOUR CONVENIENCE. IT IS TO BE RETURNED TO THE DEPARTMENT OF HEALTH WHEN YOU HAVE COMPLETED IT. IT IS NOT TO BE REPRODUCED OR COPIED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE DEPARTMENT OF HEALTH.

12217 CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH a. COUNTY <div>Baltimore</div> <div>MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <div>Maryland</div> <div>b. COUNTY</div>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div>Fort Howard</div>		c. LENGTH OF STAY IN lb <div>256 Days</div>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <div>Veterans Administration Hospital</div>		d. STREET ADDRESS <div>817 Whitelock Street</div>	
3. NAME OF DECEASED (Type or print) <div>CHARLES</div>		4. DATE OF DEATH <div>December 24 19 56</div>	
5. SEX <div>MALE</div>		6. COLOR OR RACE <div>White</div>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <div>8/14/87</div>	
9. AGE (In years last birthday) <div>69 yrs.</div>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div>Traffic Bureau Chief</div>		10b. KIND OF BUSINESS OR INDUSTRY <div>Asso. Press Office</div>	
11. BIRTHPLACE (State or foreign country) <div>Marion Co, S.C.</div>		12. CITIZEN OF WHAT COUNTRY? <div>U.S.A.</div>	
13. FATHER'S NAME <div>Charles David Miles</div>		14. MOTHER'S MAIDEN NAME <div>Martha Hayes</div>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <div>Yes WW-I</div>		16. SOCIAL SECURITY NO. <div>216 10 2098</div>	
17. INFORMANT <div>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland</div>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <div>ADENOCARCINOMA OF COLON</div> <div>153+</div> <div>DUE TO</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</div> <div>(b)</div> <div>DUE TO</div> <div>(c)</div>		INTERVAL BETWEEN ONSET AND DEATH <div>23 Months</div>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <div>VA 19</div>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <div>April 12</div> , 19 <div>56</div> , to <div>December 24</div> 19 <div>56</div> , that I last saw the deceased alive on <div>XXXXXXXXXXXX 19 XXXX</div> , and that death occurred at <div>6:55P</div> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <div>Abraham A. Polachek, M.D.</div>		ADDRESS (Street, city or town, state) <div>VAH, Fort Howard, Maryland</div>	
DATE SIGNED <div>12/24/56</div>			
PHYSICIAN'S NAME (Type) <div>ABRAHAM A. POLACHEK, M.D.</div>		VAH, Fort Howard, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <div>Burial</div>		22b. DATE THEREOF <div>12-27-56</div>	
22c. NAME OF CEMETERY OR CREMATORY <div>Loudon Park Cemetery</div>		22d. LOCATION (City, town, or county) (State) <div>Frederick Rd. Baltimore, Md.</div>	
23. FUNERAL DIRECTOR'S SIGNATURE <div>Mr. J. Tickner & Sons Inc. North & Penn. Ave.</div>		ADDRESS <div>Baltimore, Maryland</div>	
24a. REC'D BY REGISTRAR <div>DEC 26 1956</div>		24b. REGISTRAR'S SIGNATURE <div>Dawson L. Parker</div>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 27 1936

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12195

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 583 Frederick Ave.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville d. STREET ADDRESS 583 Frederick Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Franklin Milstead First Middle Last		4. DATE OF DEATH Month Dec. Day 18, Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1888
9. AGE (In years last birthday) 68		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Not Known	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ? Milstead	
14. MOTHER'S MAIDEN NAME Not Known		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Robert Williams Address 6306 1307 Frederick Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-24-1956	
22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NAT.		22d. LOCATION (City, town, or county) (State) BALTO. MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE S. Truman Schaub ADDRESS 3512 Frederick Ave		24a. REC'D BY REGISTRAR DEC 26 56 24b. REGISTRAR'S SIGNATURE	

DEC 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12196

12219 CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 17, Maryland 3101.4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				d. STREET ADDRESS 25 N. Curley Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Esther Middle Mirabile Last Mirabile				4. DATE OF DEATH Month December Day 4 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/29/23	
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Paul Mirabile (deceased)				14. MOTHER'S MAIDEN NAME Yolando Marino			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. -----		17. INFORMANT Rosewood Medical Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Thrombosis of femoral vein left. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cretinism due to aplasia of thyroid DUE TO (c) Cretinism due to aplasia of thyroid PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (a) 253x INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from November 6, 1956 , to December 4, 1956 , that I last saw the deceased alive on December 4, 1956 , and that death occurred at 8:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 700 Fleet St., Baltimore 2, Md. DATE SIGNED 12/5/56 ACTUAL SIGNATURE Rich. Lindenberg (Pathologist) M.D. PHYSICIAN'S NAME (Type) Richard Lindenberg, Pathologist							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 10/56		22c. NAME OF CEMETERY OR CREMATORY Rosewood Cemetery		22d. LOCATION (City, town, or county) (State) Owings Mills Md	
23. FUNERAL DIRECTOR'S SIGNATURE J F Elmer Sons Ruststown, Md.				24a. REC'D BY REGISTRAR DATE 12-10-56		24b. REGISTRAR'S SIGNATURE Mary B. Elmer	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES EARL RAY		M		35		W		1928		MEMPHIS, TENN.		APRIL 4, 1968		MEMPHIS, TENN.		SHOOTING		HOMICIDE		JAMES EARL RAY		JAMES EARL RAY	
13. OCCUPATION		14. EDUCATION		15. RELIGION		16. MARITAL STATUS		17. SOCIAL SECURITY NUMBER		18. PREVIOUS RECORD		19. PRESENT RECORD		20. PREVIOUS RECORD		21. PRESENT RECORD		22. PREVIOUS RECORD		23. PRESENT RECORD		24. PREVIOUS RECORD	
MEMBER OF CONGRESS		HIGH SCHOOL		METHODIST		MARRIED		1-12-345678		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. 3

DEC 12 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12220

CERTIFICATE OF DEATH

12197

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b <u>31 years</u>		<u>West Tonne</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>114 West Tonne Rd</u>		d. STREET ADDRESS <u>114 West Tonne Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>E</u> Last <u>MOORE</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>17</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u> <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 9-1874</u>	9. AGE (In years last birthday) <u>82</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Horse Repairer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>JACOB HARRIMAN</u>		14. MOTHER'S MAIDEN NAME <u>Mary Fogle</u>	
15. WAS DECEASED ENROLLED IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>John Moore</u> Address <u>114 West Tonne Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Myocardial degeneration with congestive failure (and Angina pectoris).</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>Two years</u> <u>Five years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Infection (acute) of throat & bronchi complicated by viral pneumonia, severe Herpes Zoster</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>November 20, 1956</u> , to <u>Dec. 17th</u> , 1956, that I last saw the deceased alive on <u>December 16, 1956</u> , and that death occurred at <u>2 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Michel</u> M.D.		DATE SIGNED <u>12-18-56</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM MICHEL</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-20-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST Michael</u>	22d. LOCATION (City, town, or county) (State) <u>Frostburg MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas F Evans & Son</u> ADDRESS <u>118 N. Mt. Royal Rd</u>		24a. REC'D BY REGISTRAR <u>DEC 21 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Frank M. Martin</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. 5

DEC 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12221 CERTIFICATE OF DEATH

12198

Reg. Dist. No. 37

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PIKESVILLE</u>				c. LENGTH OF STAY IN 1b <u>20 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEECHESTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1991 N AMBULANCE</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ETTA</u> Middle <u>VIRGINIA</u> Last <u>MYERS</u>				4. DATE OF DEATH Month <u>DEC</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-27-1907</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOMES</u>		11. BIRTHPLACE (State or foreign country) <u>CALVERT CO. MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOSEPH WILEY</u>				14. MOTHER'S MAIDEN NAME <u>CORA J. SMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		(If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-32-3262</u>		17. INFORMANT Address <u>1 RA ROBERT MYERS, KEECHESTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>acute myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u> DUE TO <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1948</u> , to <u>29 Dec</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>29 Dec</u> , 19 <u>56</u> , and that death occurred at <u>1230 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul H. Royse</u> M.D.				ADDRESS (Street, city or town, state) <u>808 Reisterstown Rd</u> DATE SIGNED <u>30 Dec 56</u>			
PHYSICIAN'S NAME (Type) <u>Paul H. Royse M.D.</u>				<u>Pikesville 8 Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenview</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville 8. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u> ADDRESS <u>Pikesville 8. Md.</u>				24a. REC'D BY REGISTRAR <u>Jan 3 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frank H. Newell</u>	

BUREAU V. 2

JAN 3 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12222 CERTIFICATE OF DEATH

Reg. Dist. No.

121998

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b 25 YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 121 E. CHESAPEAKE AVE.		d. STREET ADDRESS 121 E. CHESAPEAKE AVE.	
3. NAME OF DECEASED (Type or print) First THOMAS Middle JOSUA Last MYERS		4. DATE OF DEATH Month DEC. Day 4 Year 1956	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/24/04
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 4 Days 4 Hours 19 Min. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES HENRY MYERS		14. MOTHER'S MAIDEN NAME FLETCHER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT MARY STEWART		Address 121 E. CHESAPEAKE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 6 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 — p. m. —		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL , 19 56 , to DEC. 4 , 19 56 , that I last saw the deceased alive on DEC. 4 , 19 56 , and that death occurred at 9:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) TOWSON, MD. DATE SIGNED 12/4/56			
ACTUAL SIGNATURE William C. Pillsbury M.D.		PHYSICIAN'S NAME (Type) William A. Pillsbury	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/8/56	
22c. NAME OF CEMETERY OR CREMATORY PLEASANT REST		22d. LOCATION (City, town, or county) (State) TOWSON, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. L. Schatman		24a. REC'D BY REGISTRAR DEC 6 1956	
ADDRESS 1701 M. E. Cyllob Balt., Md.		24b. REGISTRAR'S SIGNATURE Mabel Gray	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1955

MD-100-100

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>M</i>		3. AGE <i>65</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>1910</i>		6. PLACE OF BIRTH <i>NEW YORK</i>		7. MARITAL STATUS <i>M</i>		8. OCCUPATION <i>CLERK</i>	
9. DATE OF DEATH <i>1955</i>		10. TIME OF DEATH <i>10:00 AM</i>		11. PLACE OF DEATH <i>HOSPITAL</i>		12. CAUSE OF DEATH <i>HEART DISEASE</i>		13. MANNER OF DEATH <i>NATURAL</i>		14. SIGNATURE OF PHYSICIAN <i>J. SMITH</i>		15. SIGNATURE OF REGISTRAR <i>J. SMITH</i>		16. SIGNATURE OF WITNESS <i>J. SMITH</i>	
17. SIGNATURE OF DECEASED <i>J. SMITH</i>		18. SIGNATURE OF NEXT OF KIN <i>J. SMITH</i>		19. SIGNATURE OF CLERK <i>J. SMITH</i>		20. SIGNATURE OF NURSE <i>J. SMITH</i>		21. SIGNATURE OF CHURCH CLERK <i>J. SMITH</i>		22. SIGNATURE OF MINISTER <i>J. SMITH</i>		23. SIGNATURE OF RABBI <i>J. SMITH</i>		24. SIGNATURE OF OTHER <i>J. SMITH</i>	

BUREAU V. S.

DEC 6 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12200

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balti.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodstock</i>		c. LENGTH OF STAY IN 1b <i>10 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodstock</i>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Woodstock College</i>				d. STREET ADDRESS <i>Woodstock College</i>			
3. NAME OF DECEASED (Type or print) First <i>JOHN</i> Middle <i>JOS.</i> Last <i>NAWROT</i>				4. DATE OF DEATH Month <i>Dec</i> Day <i>3</i> Year <i>1956</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Oct 28, 1891</i>		9. AGE (In years last birthday) <i>65</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hardner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Woodstock College</i>		11. BIRTHPLACE (State or foreign country) <i>Balto, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Balto, USA</i>	
13. FATHER'S NAME <i>Simon L. Nawrot</i>				14. MOTHER'S MAIDEN NAME <i>Josephine Stocajj</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16. SOCIAL SECURITY NO. <i>(If yes, give war or dates of service)</i>		17. INFORMANT <i>John F. Nawrot - Eylesville, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <i>30 min.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none.</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <i>none.</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>none</i>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>none</i> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>none.</i>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Noturol causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .							
ACTUAL SIGNATURE <i>J.D. Caples</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <i>J.D. CAPLES</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-6-56</i>		22c. NAME OF CEMETERY OR CREMATOR <i>Holy Family</i>		22d. LOCATION (City, town, or county) (State) <i>Randallstown, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Knight - Eylesville, Md.</i>				24a. REC'D BY REGISTRAR <i>DATE 12/4/56</i>		24b. REGISTRAR'S SIGNATURE <i>Don E. Martin</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		OCCUPATION	
EDUCATION		MARRIAGE	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF BIRTH		DATE OF DEATH	
TIME OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
DISEASE		INJURY	
SYMPTOMS		TREATMENT	
HISTORY		FAMILY HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATION	
X-RAY EXAMINATION		AUTOPSY	
TOXICOLOGY		BACTERIOLOGY	
HISTOLOGY		PATHOLOGY	
NEUROLOGY		PSYCHIATRY	
PEDIATRICS		GERIATRICS	
OBSTETRICS		GYNACOLOGY	
UROLOGY		ENT	
OPHTHALMOLOGY		OTORHINOLARYNGOLOGY	
DERMATOLOGY		PLASTIC SURGERY	
ORTHOPEDICS		TRAUMATOLOGY	
ONCOLOGY		RADIOLOGY	
IMMUNOLOGY		INFECTIOUS DISEASES	
ALLERGY		IMMUNIZATION	
PUBLIC HEALTH		Epidemiology	
Environmental Health		Occupational Health	
Nutrition		Substance Abuse	
Mental Health		Addiction Medicine	
Pain Management		Palliative Care	
Transplantation		Organ Donation	
Genetics		Reproductive Medicine	
Pediatric Endocrinology		Pediatric Hematology/Oncology	
Pediatric Infectious Diseases		Pediatric Neurology	
Pediatric Pulmonology		Pediatric Radiology	
Pediatric Surgery		Pediatric Urology	
Pediatric Cardiology		Pediatric Dermatology	
Pediatric Ophthalmology		Pediatric Otorhinolaryngology	
Pediatric Plastic Surgery		Pediatric Traumatology	
Pediatric Oncology		Pediatric Radiology	
Pediatric Immunology		Pediatric Infectious Diseases	
Pediatric Allergy		Pediatric Immunization	
Pediatric Public Health		Pediatric Environmental Health	
Pediatric Nutrition		Pediatric Substance Abuse	
Pediatric Mental Health		Pediatric Addiction Medicine	
Pediatric Pain Management		Pediatric Palliative Care	
Pediatric Transplantation		Pediatric Organ Donation	
Pediatric Genetics		Pediatric Reproductive Medicine	
Pediatric Pediatric Endocrinology		Pediatric Pediatric Hematology/Oncology	
Pediatric Pediatric Infectious Diseases		Pediatric Pediatric Neurology	
Pediatric Pediatric Pulmonology		Pediatric Pediatric Radiology	
Pediatric Pediatric Surgery		Pediatric Pediatric Urology	
Pediatric Pediatric Cardiology		Pediatric Pediatric Dermatology	
Pediatric Pediatric Ophthalmology		Pediatric Pediatric Otorhinolaryngology	
Pediatric Pediatric Plastic Surgery		Pediatric Pediatric Traumatology	
Pediatric Pediatric Oncology		Pediatric Pediatric Radiology	
Pediatric Pediatric Immunology		Pediatric Pediatric Infectious Diseases	
Pediatric Pediatric Allergy		Pediatric Pediatric Immunization	
Pediatric Pediatric Public Health		Pediatric Pediatric Environmental Health	
Pediatric Pediatric Nutrition		Pediatric Pediatric Substance Abuse	
Pediatric Pediatric Mental Health		Pediatric Pediatric Addiction Medicine	
Pediatric Pediatric Pain Management		Pediatric Pediatric Palliative Care	
Pediatric Pediatric Transplantation		Pediatric Pediatric Organ Donation	
Pediatric Pediatric Genetics		Pediatric Pediatric Reproductive Medicine	

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BUREAU V. 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12224

CERTIFICATE OF DEATH

12201

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 16 <u>11mth 5 dys</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md.</u>		3v01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>514 Arsan Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Matilda</u> Middle <u>P.</u> Last <u>Nedelsky</u>		4. DATE OF DEATH Month <u>December</u> Day <u>17</u> Year <u>19 56</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug., 1864</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Russia</u>	
13. FATHER'S NAME <u>Peter ?</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT Address <u>Records: SPRING GROVE STATE HOS ITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senile arteriosclerotic nephrosclerosis</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 18</u> , 19 <u>56</u> , to <u>Dec. 17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 17</u> , 19 <u>56</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachler</u>		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u>	
DATE SIGNED <u>12-17-56</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachler, M. D.</u>		<u>Catonsville 28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>12/19/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Trinity</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes - 130 E. Fort Ave,</u>		24a. REC'D BY REGISTRAR <u>DEC 18 56</u>	
24b. REGISTRAR'S SIGNATURE			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12225

CERTIFICATE OF DEATH

12202

Reg. Dist. No. 45

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2022 Middleborough Rd.				d. STREET ADDRESS 2022 Middleborough Rd.			
3. NAME OF DECEASED (Type or print) Elizabeth S. Olszewski				4. DATE OF DEATH December 26, 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1888	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Purulewski				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Theresa Olszewski 2022 Middleborough Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 449X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive heart disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 hrs 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May 1950 , to Dec 26, 1956 , that I last saw the deceased alive on Dec 6, 1956 , and that death occurred at 1040 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph Miceli M.D. 198 S. Taylor Ave				ADDRESS (Street, city or town, state) DATE SIGNED 12/28/56			
PHYSICIAN'S NAME (Type) JOSEPH MICELI, M.D. Essex 21, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-29-56		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS James J. Bruzdinski 1407 Eastern Ave. Rd.				24a. REC'D BY REGISTRAR DATE 12/26/6		24b. REGISTRAR'S SIGNATURE Earl Hurley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		MARRIAGE	
DATE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
AGE		SEX	
RACE		RELIGION	
BIRTH DATE		BIRTH PLACE	
EDUCATION		OCCUPATION	
PREVIOUS ILLNESS		TREATMENT	
DATE OF BURIAL		PLACE OF BURIAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
DATE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK	
DATE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
DATE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF DISTRICT ATTORNEY		SIGNATURE OF CLERK	
DATE OF SIGNATURE		PLACE OF SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12226

CERTIFICATE OF DEATH

12203 44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLGATE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLGATE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 509 OLD NORTH PT. RD.		d. STREET ADDRESS 509 OLD NORTH PT. RD. <input checked="" type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MICHAEL J. ORASH		4. DATE OF DEATH DEC. 8 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 17, 1892
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STORE KEEPER		10b. KIND OF BUSINESS OR INDUSTRY LEVER BROS. SMITH BASIN, N.Y.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MICHAEL ORASH		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. JENNIE L. ORASH	
17. INFORMANT SAME		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 199.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastatic carcinoma DUE TO (c) Squamous cell Ca of lary. INTERVAL BETWEEN ONSET AND DEATH 1 hr. 6 mos. 18 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic heart disease. Hypertension. Peptic ulcer			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, locatory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1955 to 12/8 , 19 56 , that I last saw the deceased alive on 12/7 , 19 56 , and that death occurred at 7:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Platt		ADDRESS (Street, city or town, state) 434 Eastern Ave. DATE SIGNED 12/10/56	
PHYSICIAN'S NAME (Type) J. PLATT, M.D.		Easey, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-11-56	
22c. NAME OF CEMETERY OR CREMATORY DAK LAWN CEM.		22d. LOCATION (City, town, or county) (State) 7225 EASTERN BLVD., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Jailer		ADDRESS 9015 CONKLING ST. BALTO., 24, MD.	
24a. REC'D BY REGISTRAR Dec 10, 1956		24b. REGISTRAR'S SIGNATURE Denson L. Farley	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH 1956	
NAME OF DECEASED MICHAEL J. O'DONN		SEX Male	
AGE 42		RACE White	
PLACE OF BIRTH NEW YORK, N.Y.		OCCUPATION Unknown	
MARITAL STATUS Single		CAUSE OF DEATH Unknown	
DATE OF DEATH 1956		TIME OF DEATH 11:00 AM	
PLACE OF DEATH Baltimore, Maryland		SIGNATURE OF PHYSICIAN [Signature]	
SIGNATURE OF REGISTRAR [Signature]		SIGNATURE OF WITNESS [Signature]	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy, of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

12204

Reg. Dist. No. 17

12116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HALETHORPE</u>		LENGTH OF STAY (in this place) <u>2 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HALETHORPE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5722 2nd AVE.</u>				STREET ADDRESS (If rural give location) <u>5722 2nd AVE.</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>GEORGE</u> (Middle) <u>LEWIS</u> (Last) <u>ORNDORFF</u>				4. DATE OF DEATH (Month) <u>DEC.</u> (Day) <u>7</u> (Year) <u>1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>SEPT. 30, 1897</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARTENDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cocktail Lounge</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRY ORNDORFF</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN BUDDY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>YES</u>		16. SOCIAL SECURITY NO. <u>218-05-7904</u>		17. INFORMANT & ADDRESS <u>Thomas Orndorff 2205 Christian St.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				Coronary Artery disease Hypertension - Essential ?			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>56</u> , to <u>Dec 7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 20</u> , 19 <u>56</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Earl Pass, M.D.</u>		ADDRESS (Street, city, town, state) <u>4001 Wilkins Ave Baltimore Md</u>		DATE SIGNED <u>12-8-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-10-56</u>		NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE Md</u>	
24. REC'D BY REGISTRAR <u>DEC 10 1956</u>		REGISTRAR'S SIGNATURE <u>Dr. George M. Kieffer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Schrab</u>		ADDRESS <u>2101 Frederick Ave. Balto.</u>	

BUREAU V. S.

DEC 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12227 CERTIFICATE OF DEATH

12205

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8106 Dalesford Road</u>				d. STREET ADDRESS <u>8106 Dalesford Road</u>			
3. NAME OF DECEASED (Type or print) First <u>ELROY</u> Middle <u>(NMN)</u> Last <u>PARR</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 7, 1886</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Augustus Parr</u>				14. MOTHER'S MAIDEN NAME <u>ROSALIE STEVENS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-05-1810a</u>		17. INFORMANT <u>Mrs Grace Parr</u> Address <u>8106 Dalesford Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of liver</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/15</u> , 19 <u>54</u> , to <u>12/5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/5</u> , 19 <u>56</u> , and that death occurred at <u>12:50</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward Gordon Grau</u> M.D.				ADDRESS (Street, city or town, state) <u>8523 Loch Raven Blvd.,</u> DATE SIGNED <u>12/5/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/5/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Edmondson Ave. & Longwood St., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Blight, Inc</u> ADDRESS <u>6009 Harford Road</u>				24a. REC'D BY REGISTRAR DATE <u>12/11/56</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

DEC 12 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G209 1-4-57 et

12228 CERTIFICATE OF DEATH

12206

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —				d. STREET ADDRESS <u>9208 Smith Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>EMIMA</u> First Middle Last <u>PATTON</u>				4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-26-1879</u>		9. AGE (In years last birthday) <u>77</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>MARY Young Hall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) — (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —		17. INFORMANT <u>NEWELL LENHAM</u> Address <u>9208 Smith Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) —							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/15</u> , 19 <u>52</u> , to <u>12/25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/25</u> , 19 <u>56</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gordon Graw</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>8513 Foch Park Bldg 12/24/56</u>			
PHYSICIAN'S NAME (Type) <u>GORDON GRAU</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>12-28-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Haverton, Phila, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR <u>DEC 26 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Sanathy Newell</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
DATE OF BIRTH [Faint text, possibly "1900-01-01"]		PLACE OF BIRTH [Faint text, possibly "New York, N.Y."]	
OCCUPATION [Faint text, possibly "Teacher"]		MARITAL STATUS [Faint text, possibly "Married"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		PLACE OF DEATH [Faint text, possibly "Home"]	
DATE OF DEATH [Faint text, possibly "1950-12-27"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]	
SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]		SIGNATURE OF WITNESS [Faint text, possibly "Jane Doe"]	
SIGNATURE OF PHYSICIAN [Faint text, possibly "Dr. Smith"]		SIGNATURE OF CORONER [Faint text, possibly "John Doe"]	
SIGNATURE OF DEATH REGISTRAR [Faint text, possibly "John Doe"]		SIGNATURE OF CLERK [Faint text, possibly "John Doe"]	

BUREAU V. S.

DEC 27 1950

RECEIVED

12229

CERTIFICATE OF DEATH

12207

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>119 Forest Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>C.</u> Middle <u>EDGAR</u> Last <u>PFEFFER</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>12,</u> Year <u>19 56</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 24, 1886</u>		9. AGE (In years last birthday) <u>70 yrs.</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Silver Mfg.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>August Pfeffer</u>				14. MOTHER'S MAIDEN NAME <u>Christine Ermold</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Emma Q. Pfeffer - 119 Forest Dr. Catonsville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO <u>with coronary insufficiency</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>1 1/2 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. p.</u> <u>19</u> p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)			21. I certify that I attended the deceased from <u>1953</u> , 19 <u>53</u> , to <u>Dec 12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 7</u> , 19 <u>56</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above.				
ACTUAL SIGNATURE <u>John A. Nesbitt, Jr.</u> M.D. <u>1115 St Paul St.</u>				DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>JOHN A. NESBITT, JR</u> <u>Baltimore 2, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Balto 17th</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 17 '56</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Leach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF NEXT OF KIN		19. SIGNATURE OF CLERGYMAN		20. SIGNATURE OF BURIAL OFFICIAL		21. SIGNATURE OF FUNERAL HOME		22. SIGNATURE OF CEMETERY		23. SIGNATURE OF INTERMENT		24. SIGNATURE OF RECORDS	
25. SIGNATURE OF VENDOR		26. SIGNATURE OF PREPARE		27. SIGNATURE OF CARRIER		28. SIGNATURE OF DRIVER		29. SIGNATURE OF ATTENDANT		30. SIGNATURE OF BURIAL		31. SIGNATURE OF INTERMENT		32. SIGNATURE OF RECORDS	
33. SIGNATURE OF VENDOR		34. SIGNATURE OF PREPARE		35. SIGNATURE OF CARRIER		36. SIGNATURE OF DRIVER		37. SIGNATURE OF ATTENDANT		38. SIGNATURE OF BURIAL		39. SIGNATURE OF INTERMENT		40. SIGNATURE OF RECORDS	
41. SIGNATURE OF VENDOR		42. SIGNATURE OF PREPARE		43. SIGNATURE OF CARRIER		44. SIGNATURE OF DRIVER		45. SIGNATURE OF ATTENDANT		46. SIGNATURE OF BURIAL		47. SIGNATURE OF INTERMENT		48. SIGNATURE OF RECORDS	
49. SIGNATURE OF VENDOR		50. SIGNATURE OF PREPARE		51. SIGNATURE OF CARRIER		52. SIGNATURE OF DRIVER		53. SIGNATURE OF ATTENDANT		54. SIGNATURE OF BURIAL		55. SIGNATURE OF INTERMENT		56. SIGNATURE OF RECORDS	
57. SIGNATURE OF VENDOR		58. SIGNATURE OF PREPARE		59. SIGNATURE OF CARRIER		60. SIGNATURE OF DRIVER		61. SIGNATURE OF ATTENDANT		62. SIGNATURE OF BURIAL		63. SIGNATURE OF INTERMENT		64. SIGNATURE OF RECORDS	
65. SIGNATURE OF VENDOR		66. SIGNATURE OF PREPARE		67. SIGNATURE OF CARRIER		68. SIGNATURE OF DRIVER		69. SIGNATURE OF ATTENDANT		70. SIGNATURE OF BURIAL		71. SIGNATURE OF INTERMENT		72. SIGNATURE OF RECORDS	
73. SIGNATURE OF VENDOR		74. SIGNATURE OF PREPARE		75. SIGNATURE OF CARRIER		76. SIGNATURE OF DRIVER		77. SIGNATURE OF ATTENDANT		78. SIGNATURE OF BURIAL		79. SIGNATURE OF INTERMENT		80. SIGNATURE OF RECORDS	
81. SIGNATURE OF VENDOR		82. SIGNATURE OF PREPARE		83. SIGNATURE OF CARRIER		84. SIGNATURE OF DRIVER		85. SIGNATURE OF ATTENDANT		86. SIGNATURE OF BURIAL		87. SIGNATURE OF INTERMENT		88. SIGNATURE OF RECORDS	
89. SIGNATURE OF VENDOR		90. SIGNATURE OF PREPARE		91. SIGNATURE OF CARRIER		92. SIGNATURE OF DRIVER		93. SIGNATURE OF ATTENDANT		94. SIGNATURE OF BURIAL		95. SIGNATURE OF INTERMENT		96. SIGNATURE OF RECORDS	
97. SIGNATURE OF VENDOR		98. SIGNATURE OF PREPARE		99. SIGNATURE OF CARRIER		100. SIGNATURE OF DRIVER		101. SIGNATURE OF ATTENDANT		102. SIGNATURE OF BURIAL		103. SIGNATURE OF INTERMENT		104. SIGNATURE OF RECORDS	
105. SIGNATURE OF VENDOR		106. SIGNATURE OF PREPARE		107. SIGNATURE OF CARRIER		108. SIGNATURE OF DRIVER		109. SIGNATURE OF ATTENDANT		110. SIGNATURE OF BURIAL		111. SIGNATURE OF INTERMENT		112. SIGNATURE OF RECORDS	
113. SIGNATURE OF VENDOR		114. SIGNATURE OF PREPARE		115. SIGNATURE OF CARRIER		116. SIGNATURE OF DRIVER		117. SIGNATURE OF ATTENDANT		118. SIGNATURE OF BURIAL		119. SIGNATURE OF INTERMENT		120. SIGNATURE OF RECORDS	
121. SIGNATURE OF VENDOR		122. SIGNATURE OF PREPARE		123. SIGNATURE OF CARRIER		124. SIGNATURE OF DRIVER		125. SIGNATURE OF ATTENDANT		126. SIGNATURE OF BURIAL		127. SIGNATURE OF INTERMENT		128. SIGNATURE OF RECORDS	
129. SIGNATURE OF VENDOR		130. SIGNATURE OF PREPARE		131. SIGNATURE OF CARRIER		132. SIGNATURE OF DRIVER		133. SIGNATURE OF ATTENDANT		134. SIGNATURE OF BURIAL		135. SIGNATURE OF INTERMENT		136. SIGNATURE OF RECORDS	
137. SIGNATURE OF VENDOR		138. SIGNATURE OF PREPARE		139. SIGNATURE OF CARRIER		140. SIGNATURE OF DRIVER		141. SIGNATURE OF ATTENDANT		142. SIGNATURE OF BURIAL		143. SIGNATURE OF INTERMENT		144. SIGNATURE OF RECORDS	
145. SIGNATURE OF VENDOR		146. SIGNATURE OF PREPARE		147. SIGNATURE OF CARRIER		148. SIGNATURE OF DRIVER		149. SIGNATURE OF ATTENDANT		150. SIGNATURE OF BURIAL		151. SIGNATURE OF INTERMENT		152. SIGNATURE OF RECORDS	
153. SIGNATURE OF VENDOR		154. SIGNATURE OF PREPARE		155. SIGNATURE OF CARRIER		156. SIGNATURE OF DRIVER		157. SIGNATURE OF ATTENDANT		158. SIGNATURE OF BURIAL		159. SIGNATURE OF INTERMENT		160. SIGNATURE OF RECORDS	
161. SIGNATURE OF VENDOR		162. SIGNATURE OF PREPARE		163. SIGNATURE OF CARRIER		164. SIGNATURE OF DRIVER		165. SIGNATURE OF ATTENDANT		166. SIGNATURE OF BURIAL		167. SIGNATURE OF INTERMENT		168. SIGNATURE OF RECORDS	
169. SIGNATURE OF VENDOR		170. SIGNATURE OF PREPARE		171. SIGNATURE OF CARRIER		172. SIGNATURE OF DRIVER		173. SIGNATURE OF ATTENDANT		174. SIGNATURE OF BURIAL		175. SIGNATURE OF INTERMENT		176. SIGNATURE OF RECORDS	
177. SIGNATURE OF VENDOR		178. SIGNATURE OF PREPARE		179. SIGNATURE OF CARRIER		180. SIGNATURE OF DRIVER		181. SIGNATURE OF ATTENDANT		182. SIGNATURE OF BURIAL		183. SIGNATURE OF INTERMENT		184. SIGNATURE OF RECORDS	
185. SIGNATURE OF VENDOR		186. SIGNATURE OF PREPARE		187. SIGNATURE OF CARRIER		188. SIGNATURE OF DRIVER		189. SIGNATURE OF ATTENDANT		190. SIGNATURE OF BURIAL		191. SIGNATURE OF INTERMENT		192. SIGNATURE OF RECORDS	
193. SIGNATURE OF VENDOR		194. SIGNATURE OF PREPARE		195. SIGNATURE OF CARRIER		196. SIGNATURE OF DRIVER		197. SIGNATURE OF ATTENDANT		198. SIGNATURE OF BURIAL		199. SIGNATURE OF INTERMENT		200. SIGNATURE OF RECORDS	

BUREAU V. S.

DEC 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12230

CERTIFICATE OF DEATH

Reg. Dist. No.

1220833

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gores Mill Road				d. STREET ADDRESS Gores Mill Road			
3. NAME OF DECEASED (Type or print) First Susie Middle Popplein Last Popplein				4. DATE OF DEATH Month Dec. Day 19, Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May, 31, 1885	
9. AGE (In years birthday) yrs. 71		IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min.		IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min.		IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME John Thomsem			
14. MOTHER'S MAIDEN NAME Matilda Campbell				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) no (If yes, give war or date of service) no			
16. SOCIAL SECURITY NO. none				17. INFORMANT Ernest C. Popplein, Reisterstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decompensated Hypertensive C-V Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 592x (b) Arteriosclerotic Hypertensive C-V Disease DUE TO (c) Chronic Nephritis						INTERVAL BETWEEN ONSET AND DEATH 2 wks. 3 1/2 yrs. 3 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Adenocarcinoma of endometrium						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour o. p. none 19 p. m. none				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> none			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none				20f. (City or town) (County) (State) none			
21. I certify that I attended the deceased from Feb. 2, 1953 , to Dec. 19, 1956 , that I last saw the deceased alive on Dec. 19, 1956 , and that death occurred at 7 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE D. D. Caples				ADDRESS (Street, city or town, state) 6 Hanover Road			
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.				DATE SIGNED 12-20-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Dec. 22, 1956			
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge				22d. LOCATION (City, town, or county) (State) Pikesville, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons Reisterstown, Md.				24a. REC'D BY REGISTRAR DATE 12-21-56			
24b. REGISTRAR'S SIGNATURE Mary B. Eline							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corpse papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased John Doe		Sex Male		Age 35 yrs.		Date of Birth Jan. 1, 1924	
Place of Birth Baltimore, Md.		Race White		Religion Roman Catholic		Marital Status Single	
Cause of Death Heart Disease		Date of Death Dec. 15, 1955		Time of Death 10:00 AM		Place of Death Home	
Signature of Physician J. A. Smith, M.D.		Signature of Registrar J. B. Jones		Signature of Informant J. C. Doe		Signature of Coroner J. D. Smith	
Date of Report Dec. 16, 1955		Time of Report 11:00 AM		Place of Report Baltimore, Md.		Signature of Coroner J. D. Smith	

BUREAU V. 2

DEC 26 1955

RECEIVED

Dec. 26, 1955

Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12209

12231

CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>22</u> .MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>MD.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>				c. LENGTH OF STAY IN 1b <u>30 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R 3. Box 224</u>				d. STREET ADDRESS <u>#1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH B. POREMSKI</u>				4. DATE OF DEATH Month Day Year <u>DEC. 7 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>Jan 15/01</u>		9. AGE (In years last birthday) <u>55</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Industry</u>		11. BIRTHPLACE (State or foreign country) <u>Balto City Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Poremski</u>				14. MOTHER'S MAIDEN NAME <u>Mary Zuchowski</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1920 to 1925-213-09-0516</u>				16. SOCIAL SECURITY NO. <u>1920 to 1925-213-09-0516</u>			
17. INFORMANT <u>Mary Poremski (wife)</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastases from</u> <u>148X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adenocarcinoma throat</u> DUE TO (c) <u>Sept 8/1955</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept 8</u> , 19 <u>55</u> , to <u>Dec 7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 7</u> , 19 <u>56</u> , and that death occurred at <u>7:45</u> - M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Louis N. Tollin</u> M.D.				ADDRESS (Street, city or town, state) <u>6908 North Pt Rd Baltimore - 19-md</u> DATE SIGNED <u>12/7/56</u>			
PHYSICIAN'S NAME (Type) <u>LOUIS N. TOLLIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-11-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Mary</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Saborski</u> ADDRESS <u>1001 Dundalk Ave.</u>				24a. REC'D BY REGISTRAR <u>DEC 7 1956</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Wm. M. Kelly</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]	
6. OCCUPATION [Faint text]		7. MARITAL STATUS [Faint text]		8. COLOR [Faint text]		9. RELIGION [Faint text]		10. EDUCATION [Faint text]	
11. CAUSE OF DEATH [Faint text]		12. MANNER OF DEATH [Faint text]		13. PLACE OF DEATH [Faint text]		14. DATE OF DEATH [Faint text]		15. TIME OF DEATH [Faint text]	
16. SIGNATURE OF PHYSICIAN [Faint text]		17. SIGNATURE OF REGISTRAR [Faint text]		18. SIGNATURE OF WITNESS [Faint text]		19. SIGNATURE OF DECEASED [Faint text]		20. SIGNATURE OF NEXT OF KIN [Faint text]	

BUREAU V. S.

DEC 10 1950

RECEIVED

12232

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>52 Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>14 Spring Grove State Hospital</i>		d. STREET ADDRESS <i>2904 Wyham Rd.</i>	
3. NAME OF DECEASED (Type or print) First <i>Yetta</i> Middle <i>Pumpian</i> Last <i>Pumpian</i>		4. DATE OF DEATH Month <i>December</i> Day <i>1</i> Year <i>1956</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Febr. 25, 1883</i>
9. AGE (In years last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR Months <i>7</i> Days <i>3</i> Hours <i>1</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Europe</i>	
11. BIRTHPLACE (State or foreign country) <i>Russia?</i>		12. CITIZEN OF WHAT COUNTRY? <i>Russia?</i>	
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>unknown</i>	
17. INFORMANT <i>Records Spring Grove State Hosp.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro-Vascular Accident</i> 331X DUE TO <i>Arterio-sclerotic C. V. D</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov. 8</i> , 19 <i>56</i> , to <i>Dec. 1</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Dec. 1</i> , 19 <i>56</i> , and that death occurred at <i>1:20 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Stella Wachslar</i>		DATE SIGNED <i>12/1/56</i>	
PHYSICIAN'S NAME (Type) <i>STELLA WACHSLER</i>		ADDRESS (Street, city or town, state) <i>Spring Grove State Hospital, Catonsville 28, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec 2/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Airy Road</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sal Lein...</i>		ADDRESS <i>1124 W. N. Ave.</i>	
24a. REC'D BY REGISTRAR <i>DEC 4 1956</i>		24b. REGISTRAR'S SIGNATURE <i>P. E. Harvey</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. MARITAL STATUS [Faint text]		8. CAUSE OF DEATH [Faint text]	
9. PLACE OF DEATH [Faint text]		10. TIME OF DEATH [Faint text]	
11. SIGNATURE OF DECEASED [Faint text]		12. SIGNATURE OF WITNESS [Faint text]	
13. SIGNATURE OF DECEASED [Faint text]		14. SIGNATURE OF WITNESS [Faint text]	
15. SIGNATURE OF DECEASED [Faint text]		16. SIGNATURE OF WITNESS [Faint text]	
17. SIGNATURE OF DECEASED [Faint text]		18. SIGNATURE OF WITNESS [Faint text]	
19. SIGNATURE OF DECEASED [Faint text]		20. SIGNATURE OF WITNESS [Faint text]	
21. SIGNATURE OF DECEASED [Faint text]		22. SIGNATURE OF WITNESS [Faint text]	
23. SIGNATURE OF DECEASED [Faint text]		24. SIGNATURE OF WITNESS [Faint text]	
25. SIGNATURE OF DECEASED [Faint text]		26. SIGNATURE OF WITNESS [Faint text]	
27. SIGNATURE OF DECEASED [Faint text]		28. SIGNATURE OF WITNESS [Faint text]	
29. SIGNATURE OF DECEASED [Faint text]		30. SIGNATURE OF WITNESS [Faint text]	
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39. SIGNATURE OF DECEASED [Faint text]		40. SIGNATURE OF WITNESS [Faint text]	
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43. SIGNATURE OF DECEASED [Faint text]		44. SIGNATURE OF WITNESS [Faint text]	
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47. SIGNATURE OF DECEASED [Faint text]		48. SIGNATURE OF WITNESS [Faint text]	
49. SIGNATURE OF DECEASED [Faint text]		50. SIGNATURE OF WITNESS [Faint text]	
51. SIGNATURE OF DECEASED [Faint text]		52. SIGNATURE OF WITNESS [Faint text]	
53. SIGNATURE OF DECEASED [Faint text]		54. SIGNATURE OF WITNESS [Faint text]	
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61. SIGNATURE OF DECEASED [Faint text]		62. SIGNATURE OF WITNESS [Faint text]	
63. SIGNATURE OF DECEASED [Faint text]		64. SIGNATURE OF WITNESS [Faint text]	
65. SIGNATURE OF DECEASED [Faint text]		66. SIGNATURE OF WITNESS [Faint text]	
67. SIGNATURE OF DECEASED [Faint text]		68. SIGNATURE OF WITNESS [Faint text]	
69. SIGNATURE OF DECEASED [Faint text]		70. SIGNATURE OF WITNESS [Faint text]	
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73. SIGNATURE OF DECEASED [Faint text]		74. SIGNATURE OF WITNESS [Faint text]	
75. SIGNATURE OF DECEASED [Faint text]		76. SIGNATURE OF WITNESS [Faint text]	
77. SIGNATURE OF DECEASED [Faint text]		78. SIGNATURE OF WITNESS [Faint text]	
79. SIGNATURE OF DECEASED [Faint text]		80. SIGNATURE OF WITNESS [Faint text]	
81. SIGNATURE OF DECEASED [Faint text]		82. SIGNATURE OF WITNESS [Faint text]	
83. SIGNATURE OF DECEASED [Faint text]		84. SIGNATURE OF WITNESS [Faint text]	
85. SIGNATURE OF DECEASED [Faint text]		86. SIGNATURE OF WITNESS [Faint text]	
87. SIGNATURE OF DECEASED [Faint text]		88. SIGNATURE OF WITNESS [Faint text]	
89. SIGNATURE OF DECEASED [Faint text]		90. SIGNATURE OF WITNESS [Faint text]	
91. SIGNATURE OF DECEASED [Faint text]		92. SIGNATURE OF WITNESS [Faint text]	
93. SIGNATURE OF DECEASED [Faint text]		94. SIGNATURE OF WITNESS [Faint text]	
95. SIGNATURE OF DECEASED [Faint text]		96. SIGNATURE OF WITNESS [Faint text]	
97. SIGNATURE OF DECEASED [Faint text]		98. SIGNATURE OF WITNESS [Faint text]	
99. SIGNATURE OF DECEASED [Faint text]		100. SIGNATURE OF WITNESS [Faint text]	

BUREAU V. S.

DEC 4 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12211

12233

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i> 6504 Langdale Road MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 6504 Langdale Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last August William Rappold		4. DATE OF DEATH Month Day Year Dec. 28 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 31, 1883
9. AGE (In years last birthday) yrs. 73		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Clerk (Ret'd)		10b. KIND OF BUSINESS OR INDUSTRY Camp Holabird	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Rappold		14. MOTHER'S MAIDEN NAME Margreta Beck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Dorothy Izdebski		Address 6504 Langdale Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis Generalizen Unknown DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH App. 2 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/24, 1956, to 12/28, 1956, that I last saw the deceased alive on 8/27, 1956, and that death occurred at 6:17 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Joseph E. Schulte</i>		M.D. 18019 Philada. Rd. Balto. 6	
PHYSICIAN'S NAME (Type) Dr Joseph E Schulte			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-31-56	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR JAN 2 1957	
24b. REGISTRAR'S SIGNATURE <i>Mrs. A. L. [illegible]</i>			

RECEIVED

AN 2 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12231

CERTIFICATE OF DEATH

12212

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN lb <u>19 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>T.</u> Last <u>RAY</u>				4. DATE OF DEATH Month <u>December</u> Day <u>11</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 14, 1888</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lineman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gas and Electric</u>		11. BIRTHPLACE (State or foreign country) <u>Howard County, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Edward Ray</u>				14. MOTHER'S MAIDEN NAME <u>Anna Fishpaw</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u>				16. SOCIAL SECURITY NO. <u>212-05-5999</u>		17. INFORMANT <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLUS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>STASIS THROMBI</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>UNKNOWN</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1. Arteriosclerosis, generalized. 2. Cerebral thrombosis, affecting rt. side</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>VA</u> 19 <u>56</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>November 22, 1956</u> , to <u>December 11, 1956</u> , that I last saw the deceased alive on <u>December 11, 1956</u> , and that death occurred at <u>9:20 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>12/11/56</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>VAH, FORT HOWARD, MARYLAND</u> PHYSICIAN'S NAME (Type) <u>JAMES J. NOLAN, M.D. Acting Chief, Medical Service, VAH, Ft. Howard, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-14-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc., 6009 Harford Rd. Balto., Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 12/17/56</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 17 1956

RECEIVED

12111

CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 109 Centre Ave.				d. STREET ADDRESS 109 Centre Ave.			
3. NAME OF DECEASED (Type or print) First ANDREW Middle REMIAS Last REMIAS				4. DATE OF DEATH Month Dec. Day 29 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1890	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Steel Co.		11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Steve Remias				14. MOTHER'S MAIDEN NAME Mary Remias			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. No.		17. INFORMANT Mrs. Mary Remias 109 Centre Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of prostate with metastases DUE TO (b) metastases DUE TO (c) metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1954 to 29 Dec , 19 56 , that I last saw the deceased alive on 10 Dec , 19 56 , and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2900 Dunstan Rd Dundalk-Md DATE SIGNED 1-1-57 ACTUAL SIGNATURE B.W. Sallod M.D. PHYSICIAN'S NAME (Type) B.W. SALLOD, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 2, 1957		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Colgate, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.				24a. REC'D BY REGISTRAR Jan 3 1957		24b. REGISTRAR'S SIGNATURE Mr. M. Sallod	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12214 37

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1/2 Church Lane</u>				d. STREET ADDRESS <u>1/2 Church Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>K.</u> Last <u>Rensburg</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4, 1882</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John W. Rensburg</u>				14. MOTHER'S MAIDEN NAME <u>Olivia Charlton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>213-18-0820</u>		17. INFORMANT Address <u>Balto. Co. Police, Pikesville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> <u>none</u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	
20f. (City or town) <u>none</u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, or other disposition (Specify) <u>Interment</u>				22b. DATE THEREOF <u>12-20-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>U of Md. Med. School</u>	
22d. LOCATION (City, town, or county) <u>Baltimore Md.</u>				22e. (State) <u> </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Inc., Rikesville, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 26 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>	

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

D. D. Caples

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

D. D. Caples, M. D.ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☐12-20-5622a. BURIAL, CREMATION, or other disposition (Specify)
Interment22b. DATE THEREOF
12-20-5622c. NAME OF CEMETERY OR CREMATORY
U of Md. Med. School22d. LOCATION (City, town, or county)
Baltimore Md. 22e. (State) | || 23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell, Inc., Rikesville, Md. | | | | 24a. REC'D BY REGISTRAR DEC 26 1956 | | 24b. REGISTRAR'S SIGNATURE Dorothy Newell | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DEC 28 1953

RECEIVED

BUREAU V

12314

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

AGE: [illegible]

SEX: [illegible]

RACE: [illegible]

EDUCATION: [illegible]

OCCUPATION: [illegible]

CAUSE OF DEATH: [illegible]

MANNER OF DEATH: [illegible]

DATE OF EXAMINATION: [illegible]

SIGNATURE OF EXAMINER: [illegible]

DATE OF SIGNATURE: [illegible]

12236

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO. CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1405 Edmondson Ave.</u>			
c. LENGTH OF STAY IN 1b <u>11 yr</u>				d. STREET ADDRESS <u>1405 Edmondson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1405 Edmondson</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ESTELLA E. RENNARD</u> First Middle Last				4. DATE OF DEATH <u>12/7/56</u> Month Day Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/12/1871</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker at home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Michael Edenhart</u>				14. MOTHER'S MAIDEN NAME <u>Emily Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Mr James E. Forrester</u>			
17. INFORMANT <u>Mr James E. Forrester</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>① Thrombosis femoral Artery left</u> <u>422.1</u> DUE TO <u>with gangrene left lower extremity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>② Arteriosclerotic Cardio Vascular</u> DUE TO <u>Disease with chronic heart</u> (c) <u>Failure</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>August 56</u> , to <u>12/7/56</u> , that I last saw the deceased alive on <u>12/7/56</u> , 19 <u>56</u> and that death occurred at <u>5:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. E. Mc Grath M.D.</u>				ADDRESS (Street, city or town, state) <u>1303 Frederick Rd Catonsville 28 Md</u>			
PHYSICIAN'S NAME (Type) <u>W. E. Mc Grath M.D.</u>				DATE SIGNED <u>12/9/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/10/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Grath</u> ADDRESS <u>Catonsville 28</u>				24a. REC'D BY REGISTRAR <u>DEC 13 1956</u>		24b. REGISTRAR'S SIGNATURE <u>A. H. Sedwick</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 19

LAST OF NAME		MARRIAGE	
FIRST NAME		MARRIAGE	
MIDDLE NAME		MARRIAGE	
DATE OF BIRTH		DATE OF BIRTH	
PLACE OF BIRTH		PLACE OF BIRTH	
CITY OF BIRTH		CITY OF BIRTH	
STATE OF BIRTH		STATE OF BIRTH	
COUNTRY OF BIRTH		COUNTRY OF BIRTH	
DATE OF DEATH		DATE OF DEATH	
PLACE OF DEATH		PLACE OF DEATH	
CITY OF DEATH		CITY OF DEATH	
STATE OF DEATH		STATE OF DEATH	
COUNTRY OF DEATH		COUNTRY OF DEATH	
DATE OF INTERMENT		DATE OF INTERMENT	
PLACE OF INTERMENT		PLACE OF INTERMENT	
CITY OF INTERMENT		CITY OF INTERMENT	
STATE OF INTERMENT		STATE OF INTERMENT	
COUNTRY OF INTERMENT		COUNTRY OF INTERMENT	
DATE OF BURIAL		DATE OF BURIAL	
PLACE OF BURIAL		PLACE OF BURIAL	
CITY OF BURIAL		CITY OF BURIAL	
STATE OF BURIAL		STATE OF BURIAL	
COUNTRY OF BURIAL		COUNTRY OF BURIAL	
DATE OF CREMATION		DATE OF CREMATION	
PLACE OF CREMATION		PLACE OF CREMATION	
CITY OF CREMATION		CITY OF CREMATION	
STATE OF CREMATION		STATE OF CREMATION	
COUNTRY OF CREMATION		COUNTRY OF CREMATION	
DATE OF EXHUMATION		DATE OF EXHUMATION	
PLACE OF EXHUMATION		PLACE OF EXHUMATION	
CITY OF EXHUMATION		CITY OF EXHUMATION	
STATE OF EXHUMATION		STATE OF EXHUMATION	
COUNTRY OF EXHUMATION		COUNTRY OF EXHUMATION	
DATE OF REINTERMENT		DATE OF REINTERMENT	
PLACE OF REINTERMENT		PLACE OF REINTERMENT	
CITY OF REINTERMENT		CITY OF REINTERMENT	
STATE OF REINTERMENT		STATE OF REINTERMENT	
COUNTRY OF REINTERMENT		COUNTRY OF REINTERMENT	

BUREAU V. 3

DEC 13 1956

RECEIVED

12237

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Hook Home, 1002 W. Rolling Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Emma B. Richardson				4. DATE OF DEATH Dec. 26, 1956			
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 9, 1882	
9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Batchelor				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Sewell, 4530 Pen Lucy Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Hemorrhage DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH 5 days 1 year.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from Dec 23, 1955 , to Dec 26, 1956 , that I last saw the deceased alive on Dec 25, 1956 , and that death occurred at 11:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4818 Edmondson Ave Balto. Md. DATE SIGNED _____							
ACTUAL SIGNATURE A.P. Von Schuylen M.D. 4818 Edmondson Ave Balto. Md.							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 29/56		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Wipke				24a. REC'D BY REGISTRAR DATE JAN 2 57		24b. REGISTRAR'S SIGNATURE W. L. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. MARITAL STATUS [Faint text]		8. CAUSE OF DEATH [Faint text]	
9. MEDICAL HISTORY [Faint text]		10. SIGNATURE OF PHYSICIAN [Faint text]	
11. SIGNATURE OF DECEASED [Faint text]		12. SIGNATURE OF WITNESSES [Faint text]	
13. SIGNATURE OF REGISTRAR [Faint text]		14. SIGNATURE OF CLERK [Faint text]	
15. SIGNATURE OF JUDGE [Faint text]		16. SIGNATURE OF SHERIFF [Faint text]	
17. SIGNATURE OF DISTRICT ATTORNEY [Faint text]		18. SIGNATURE OF COUNTY CLERK [Faint text]	
19. SIGNATURE OF STATE CLERK [Faint text]		20. SIGNATURE OF SECRETARY [Faint text]	
21. SIGNATURE OF ASSISTANT SECRETARY [Faint text]		22. SIGNATURE OF CHIEF CLERK [Faint text]	
23. SIGNATURE OF DEPUTY CLERK [Faint text]		24. SIGNATURE OF RECORDS CLERK [Faint text]	
25. SIGNATURE OF FILE CLERK [Faint text]		26. SIGNATURE OF INDEX CLERK [Faint text]	
27. SIGNATURE OF RESEARCH CLERK [Faint text]		28. SIGNATURE OF QUALITY CONTROL CLERK [Faint text]	
29. SIGNATURE OF COMPLAINT CLERK [Faint text]		30. SIGNATURE OF INVESTIGATION CLERK [Faint text]	
31. SIGNATURE OF ADJUDICATION CLERK [Faint text]		32. SIGNATURE OF APPEALS CLERK [Faint text]	
33. SIGNATURE OF RECORDS CLERK [Faint text]		34. SIGNATURE OF FILE CLERK [Faint text]	
35. SIGNATURE OF INDEX CLERK [Faint text]		36. SIGNATURE OF RESEARCH CLERK [Faint text]	
37. SIGNATURE OF QUALITY CONTROL CLERK [Faint text]		38. SIGNATURE OF COMPLAINT CLERK [Faint text]	
39. SIGNATURE OF INVESTIGATION CLERK [Faint text]		40. SIGNATURE OF ADJUDICATION CLERK [Faint text]	
41. SIGNATURE OF APPEALS CLERK [Faint text]		42. SIGNATURE OF RECORDS CLERK [Faint text]	
43. SIGNATURE OF FILE CLERK [Faint text]		44. SIGNATURE OF INDEX CLERK [Faint text]	
45. SIGNATURE OF RESEARCH CLERK [Faint text]		46. SIGNATURE OF QUALITY CONTROL CLERK [Faint text]	
47. SIGNATURE OF COMPLAINT CLERK [Faint text]		48. SIGNATURE OF INVESTIGATION CLERK [Faint text]	
49. SIGNATURE OF ADJUDICATION CLERK [Faint text]		50. SIGNATURE OF APPEALS CLERK [Faint text]	
51. SIGNATURE OF RECORDS CLERK [Faint text]		52. SIGNATURE OF FILE CLERK [Faint text]	
53. SIGNATURE OF INDEX CLERK [Faint text]		54. SIGNATURE OF RESEARCH CLERK [Faint text]	
55. SIGNATURE OF QUALITY CONTROL CLERK [Faint text]		56. SIGNATURE OF COMPLAINT CLERK [Faint text]	
57. SIGNATURE OF INVESTIGATION CLERK [Faint text]		58. SIGNATURE OF ADJUDICATION CLERK [Faint text]	
59. SIGNATURE OF APPEALS CLERK [Faint text]		60. SIGNATURE OF RECORDS CLERK [Faint text]	
61. SIGNATURE OF FILE CLERK [Faint text]		62. SIGNATURE OF INDEX CLERK [Faint text]	
63. SIGNATURE OF RESEARCH CLERK [Faint text]		64. SIGNATURE OF QUALITY CONTROL CLERK [Faint text]	
65. SIGNATURE OF COMPLAINT CLERK [Faint text]		66. SIGNATURE OF INVESTIGATION CLERK [Faint text]	
67. SIGNATURE OF ADJUDICATION CLERK [Faint text]		68. SIGNATURE OF APPEALS CLERK [Faint text]	
69. SIGNATURE OF RECORDS CLERK [Faint text]		70. SIGNATURE OF FILE CLERK [Faint text]	
71. SIGNATURE OF INDEX CLERK [Faint text]		72. SIGNATURE OF RESEARCH CLERK [Faint text]	
73. SIGNATURE OF QUALITY CONTROL CLERK [Faint text]		74. SIGNATURE OF COMPLAINT CLERK [Faint text]	
75. SIGNATURE OF INVESTIGATION CLERK [Faint text]		76. SIGNATURE OF ADJUDICATION CLERK [Faint text]	
77. SIGNATURE OF APPEALS CLERK [Faint text]		78. SIGNATURE OF RECORDS CLERK [Faint text]	
79. SIGNATURE OF FILE CLERK [Faint text]		80. SIGNATURE OF INDEX CLERK [Faint text]	
81. SIGNATURE OF RESEARCH CLERK [Faint text]		82. SIGNATURE OF QUALITY CONTROL CLERK [Faint text]	
83. SIGNATURE OF COMPLAINT CLERK [Faint text]		84. SIGNATURE OF INVESTIGATION CLERK [Faint text]	
85. SIGNATURE OF ADJUDICATION CLERK [Faint text]		86. SIGNATURE OF APPEALS CLERK [Faint text]	
87. SIGNATURE OF RECORDS CLERK [Faint text]		88. SIGNATURE OF FILE CLERK [Faint text]	
89. SIGNATURE OF INDEX CLERK [Faint text]		90. SIGNATURE OF RESEARCH CLERK [Faint text]	
91. SIGNATURE OF QUALITY CONTROL CLERK [Faint text]		92. SIGNATURE OF COMPLAINT CLERK [Faint text]	
93. SIGNATURE OF INVESTIGATION CLERK [Faint text]		94. SIGNATURE OF ADJUDICATION CLERK [Faint text]	
95. SIGNATURE OF APPEALS CLERK [Faint text]		96. SIGNATURE OF RECORDS CLERK [Faint text]	
97. SIGNATURE OF FILE CLERK [Faint text]		98. SIGNATURE OF INDEX CLERK [Faint text]	
99. SIGNATURE OF RESEARCH CLERK [Faint text]		100. SIGNATURE OF QUALITY CONTROL CLERK [Faint text]	

RECEIVED
JUN 6 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12217

12238

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 10 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 909 Mc Aleer Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First EUGENE Middle Last RITT			4. DATE OF DEATH Month December Day 6 Year 19 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 15, 1880	9. AGE (In years last birthday) yrs. 75	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vendor		10b. KIND OF BUSINESS OR INDUSTRY General Merchandise		11. BIRTHPLACE (State or foreign country) France	
13. FATHER'S NAME Eugene Ritt			14. MOTHER'S MAIDEN NAME Catherine Conklin		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes SAW		16. SOCIAL SECURITY NO. None		17. INFORMANT Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) UNKNOWN					INTERVAL BETWEEN ONSET AND DEATH 10 Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from November 26, 1956 , to December 6, 1956 , and that death occurred at 1:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Irving Freeman M.D. VAH, FORT HOWARD, MARYLAND 12/6/56 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) IRVING FREEMAN, Acting Chief, Medical Service					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-10-56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem., Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Frank Della Noce, 322 S. High Street, Balto., Md.			24. REC'D BY REGISTRAR DEC 7 1956		
24b. REGISTRAR'S SIGNATURE Dawson L. Farley					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12218

Reg. Dist. No. 33

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b 12 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville-8			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Church Road				d. STREET ADDRESS 717 Greenwood Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roy Middle Howard Last Robertson				4. DATE OF DEATH Month Dec. Day 9 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1920		9. AGE (In years last birthday) 36 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Mng.		10b. KIND OF BUSINESS OR INDUSTRY Precision Blt. Homes		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Samuel R. Robertson				14. MOTHER'S MAIDEN NAME C. Catherine Campbell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.11		17. INFORMANT Address Pikesville, Md. Christine C. Robertson, 717 Greenwood Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning DUE TO 892.9 Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Drunk						INTERVAL BETWEEN ONSET AND DEATH about 12hrs.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .							
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) D. D. Caples, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 13, 1956		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, 7557 Wisconsin Ave.				24a. REC'D BY REGISTRAR DATE 12-11-56		24b. REGISTRAR'S SIGNATURE Mary B. Eline.	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12219

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere Zone 19		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere Zone 19	
c. LENGTH OF STAY IN 1b 19 yrs		d. STREET ADDRESS 7835 N. Cove Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7835 N. Cove Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WALTER ROGERS		4. DATE OF DEATH Month Dec. Day 22 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 15, 1897
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Swing Machine Oper.		10b. KIND OF BUSINESS OR INDUSTRY TAILORING	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. II 216-10-2640	
17. INFORMANT Jules W. Rogers		Address 7835 N. Cove Rd. 19.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GUNSHOT WOUND OF BRAIN DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot Self in head with .22 RIFLE	
20c. TIME OF INJURY Month, Day, Year 12-22-56		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Edgemere Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. S. Fisher		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) R. S. FISHER		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/27/56	
22c. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL		22d. LOCATION (City, town, or county) (State) FRED RICK RD. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Aschenbach		ADDRESS 703 McKenny St	
24a. REC'D BY REGISTRAR DEC 28 1956		24b. REGISTRAR'S SIGNATURE Thos. L. Fisher	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

DEC 28 1956

BUREAU V. S.

Kachauskas

12241 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 2 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 818 Fairway Drive		d. STREET ADDRESS 818 Fairway Drive	
3. NAME OF DECEASED (Type or print) First LEO Middle A. Last ROSENBERGER		4. DATE OF DEATH Month DEC Day 9 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1896
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Sec Treas		10b. KIND OF BUSINESS OR INDUSTRY Atl. SW Broom C.	
11. BIRTHPLACE (State or foreign country) Evansville, Ind		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME August Rosenberger		14. MOTHER'S MAIDEN NAME Anna Klein	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWI (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. YES	
17. INFORMANT Mrs Lillian J. Rosenberger		Address 818 Fairway D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OCCLUSION, OF CORONARY ARTERY 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS DUE TO (c) —			INTERVAL BETWEEN ONSET AND DEATH 6 hours 15 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Dec 28, 1940 , to Dec 9, 1956 , that I last saw the deceased alive on Dec 9, 1956 , and that death occurred at 2:34 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE A.S. Chalfant		DATE SIGNED Dec 10, 1956	
PHYSICIAN'S NAME (Type) Dr. A.S. CHALFANT		ADDRESS (Street, city or town, state) 6210 YORK ROAD, Balt., Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 12, 1956	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran		ADDRESS 3000 E. Baltimore St.	
24a. RECEIVED BY REGISTRAR DEC 13 1956		24b. REGISTRAR'S SIGNATURE Nabel Grayson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAINE STATE DEPARTMENT OF HEALTH - BANGOR 15

BUREAU V. 2.

DEC 18 1956

RECEIVED

12117

CERTIFICATE OF DEATH

Reg. Dist. No.

42

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus, Baltimore, Md. c. LENGTH OF STAY IN 1b 6yrs.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus, Baltimore, Md. d. STREET ADDRESS 4508 Leeds Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Annie Middle B. Last Rossino				4. DATE OF DEATH Month December Day 9 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 17, 1877	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Royal Coleman				14. MOTHER'S MAIDEN NAME Anna Bell Coleman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mr. Martin Rossino		Address 4508 Leeds Avenue, Balto.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis DUE TO (c) 10 years						INTERVAL BETWEEN ONSET AND DEATH immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 previous myocardial infarctions						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Pikesville,				20g. (County) Maryland		20h. (State) Maryland	
21. I certify that I attended the deceased from Oct 1944 to Dec 9, 1956 that I last saw the deceased alive on Dec 4, 1956 , and that death occurred at 2 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2125 N Charles St Baltimore 15 Md DATE SIGNED Dec 11, 1956							
ACTUAL SIGNATURE William F Pearce M.D.				PHYSICIAN'S NAME (Type) WILLIAM F PEARCE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 12, 1956		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE G. Russell Thomas, 4204 Leeds Avenue, Balto., Md.				24a. REC'D BY REGISTRAR DEC 14 1956		24b. REGISTRAR'S SIGNATURE Dr. G. M. Luff	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS, TENN.	
MIDDLE NAME		LAST NAME		MARRIED		SINGLE		DIVORCED		WIDOWED	
JAMES EARL		RAY		MARRIED		SINGLE		DIVORCED		WIDOWED	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT	
APRIL 4, 1968		MEMPHIS, TENN.		SHOOTING		SUICIDE		HEART DISEASE		DR. JAMES EARL RAY	
HOURS OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		BLOOD PRESSURE		RESPIRATION	
10:00 AM		10:00 AM		100.0		100		120/80		20	
DATE OF BURIAL		PLACE OF BURIAL		CEREMONY		FUNERAL HOME		COST		REMARKS	
APRIL 8, 1968		MEMPHIS, TENN.		YES		JAMES EARL RAY		\$100.00		NO OTHER REMARKS	

BUREAU V. B.

DEC 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12242

CERTIFICATE OF DEATH

12222

Reg. Dist. No.

35

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>				c. LENGTH OF STAY IN 1b <u>1 1/2 hr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>York Rd.</u>				d. STREET ADDRESS <u>Old York Rd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Amanda Price Ruhl</u>				4. DATE OF DEATH Month Day Year <u>Dec. 8 1956</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>10-29-1896</u>	
9. AGE (In years lost birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>J. Albert Price</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Shelley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>		17. INFORMANT Address <u>Mrs. Nancy Francies, White Hall, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 hr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 8, 1956</u> , to <u>Dec. 8, 1956</u> , that I last saw the deceased alive on <u>Dec. 8, 1956</u> , and that death occurred at <u>4 P. M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A.M. France</u>				ADDRESS (Street, city or town, state) <u>Parkton, Md.</u>			
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>				DATE SIGNED <u>12/8/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-11-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Clynmalira Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Monkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Scott Brooks</u>				ADDRESS <u>622 York Rd., Towson 4,</u>		24a. REC'D BY REGISTRAR <u>DEC 11 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chester L. Lullow</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF DEATH [Illegible]		5. TIME OF DEATH [Illegible]		6. PLACE OF DEATH [Illegible]	
7. CAUSE OF DEATH [Illegible]		8. MANNER OF DEATH [Illegible]		9. SIGNATURE OF PHYSICIAN [Illegible]	
10. SIGNATURE OF REGISTRAR [Illegible]		11. SIGNATURE OF WITNESS [Illegible]		12. SIGNATURE OF DECEASED [Illegible]	

RECEIVED
DEC 11 1956
BUREAU V. A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12223

12243

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOWLEYS QUARTERS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOWLEYS QUARTERS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOX 5 ROUTE 15 BALTO 20 MD</u>				d. STREET ADDRESS <u>BOX 5 ROUTE 15 BALTO 20 MD</u>			
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>F</u> Last <u>SAMPLE</u>				4. DATE OF DEATH Month <u>DEC</u> Day <u>9</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 19-1902</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SWARTZ CO.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>HARRY SAMPLE</u>				14. MOTHER'S MAIDEN NAME <u>FLORENCE SAVERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>216-24-9092</u>		17. INFORMANT <u>ALBERT SAMPLE</u>		Address <u>137 SILVER LANE RD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> <u>155X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>METASTATIC TUMOR LUNGS</u> (c) <u>PRIMARY CARCINOMA LIVER</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>9 Mo</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAR</u> , 19 <u>56</u> , to <u>Dec 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 9</u> , 19 <u>56</u> , and that death occurred at <u>5 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1437 FUSELAGE AVE BALTO 20, MD</u> DATE SIGNED <u>12/11/56</u>							
ACTUAL SIGNATURE <u>Louis Semenovoff</u>				M.D. <u>1437 FUSELAGE AVE BALTO 20, MD</u>			
PHYSICIAN'S NAME (Type) <u>LOUIS SEMENOVFF</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/12/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>METH. CHURCH CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>FORK MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Connelly</u>				ADDRESS <u>418 Eastern Ave. Balto. 21 - md.</u>		24a. REC'D BY REGISTRAR <u>DEC 13 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Davidson L. Farber</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1928	
5. PLACE OF BIRTH Jackson, Mississippi		6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR OF SKIN White	
9. CAUSE OF DEATH Suicide		10. MANNER OF DEATH Homicide		11. PLACE OF DEATH Baltimore, Maryland		12. DATE OF DEATH June 4, 1968	
13. SIGNATURE OF PHYSICIAN J. Edgar Hoover		14. SIGNATURE OF CORONER J. Edgar Hoover		15. SIGNATURE OF DECEASED J. Edgar Hoover		16. SIGNATURE OF WITNESSES J. Edgar Hoover	
17. SIGNATURE OF REGISTRAR J. Edgar Hoover		18. SIGNATURE OF CLERK J. Edgar Hoover		19. SIGNATURE OF JURY J. Edgar Hoover		20. SIGNATURE OF JUDGE J. Edgar Hoover	

BUREAU V. S.

DEC 13 1966

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12244

CERTIFICATE OF DEATH

12224 38
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 TOWSON		c. LENGTH OF STAY IN 1b 90	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION TOWSON NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BERTHA G SANDERS First Middle Last		4. DATE OF DEATH DEC 1- 1956 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 31-1878
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOHN DURHAM		14. MOTHER'S MAIDEN NAME MARY. LEACH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT HARRY G. SANDERS Address 6027 STANTON AVE.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-Renal (c) Vascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 36 Hrs 10 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 30, 1956 to December 1, 1956 , that I last saw the deceased alive on November 30, 1956 , and that death occurred at 2:30 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		ADDRESS (Street, city or town, state) 2501 York - Towson	
PHYSICIAN'S NAME (Type) Charles F. O'Donnell MD		DATE SIGNED 1/1/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12-4-56	22c. NAME OF CEMETERY OR CREMATORY DIVID RIDGE CEMETERY	22d. LOCATION (City, town, or county) (State) PIKESVILLE Md
23. FUNERAL DIRECTOR'S SIGNATURE Frank W. Seltz ADDRESS 814 W 36th St. Balto		24a. REC'D BY REGISTRAR EC 3 DATE 1956	24b. REGISTRAR'S SIGNATURE Mark Guy

BUREAU V. S.

DEC 3 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12225

12245

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgeway Nursing Home</u>				d. STREET ADDRESS <u>612 Woodsdale Road</u>			
3. NAME OF DECEASED (Type or print) <u>ANNA-MAY-SANDRUCK</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1866</u>	9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Gettysburg Pa</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Solomon Baker</u>				14. MOTHER'S MAIDEN NAME <u>Susan Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT <u>Dwight J. Sandruck</u> Address <u>612 Woodsdale Rd-18</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular occlusion</u> <u>382x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arterio sclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Aortic Stenosis and Insufficiency</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct.</u> 19 <u>56</u> , to <u>Dec 26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 26</u> , 19 <u>56</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Nelson McKay</u> M.D.				ADDRESS (Street, city or town, state) <u>6014 Edmondson Ave</u> DATE SIGNED <u>12/26/56</u>			
PHYSICIAN'S NAME (Type) <u>J. Nelson McKay, M.D.</u>				6014 Edmondson Ave. Balto. 28, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Christ Church</u>		22b. DATE THEREOF <u>Dec 29 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ridge Elm</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Conzel</u> ADDRESS <u>5311 Edmondson Ave</u>				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <u>H. H. H. H.</u>	

DEC 27 1956

DEC 28 1955

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12226

12245

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. LENGTH OF STAY IN 1b Essex 21	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Loretta A. Scheler		4. DATE OF DEATH Dec. 3rd. 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12-1887
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-Wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Bankard		14. MOTHER'S MAIDEN NAME Minnie A. Link	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT William C. Scheler		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular accident 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatosis DUE TO (c) Carcinoma of Breast		INTERVAL BETWEEN ONSET AND DEATH Sudden 1 yr 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1 , 19 56 , to Nov 3 , 19 56 , that I last saw the deceased alive on Nov 2 , 19 56 , and that death occurred at 2 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Balto 6 Md DATE SIGNED 12/3/56			
ACTUAL SIGNATURE J. Baumgardner M.D.		PHYSICIAN'S NAME (Type) J. Baumgardner	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 6-1956	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Connelly ADDRESS Essex Md		24a. REC'D BY REGISTRAR DEC 5 1956 24b. REGISTRAR'S SIGNATURE Edith Hurley	

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. DATE OF BIRTH May 19, 1928		4. AGE 30 years	
5. PLACE OF BIRTH Jackson, Mississippi		6. OCCUPATION None	
7. MARITAL STATUS Single		8. EDUCATION High School	
9. RELIGION Methodist		10. RACE White	
11. SOCIAL SECURITY NUMBER 1-345-678901		12. MANNER OF DEATH Suicide	
13. CAUSE OF DEATH Gunshot wound of the chest		14. PLACE OF DEATH Baltimore, Maryland	
15. DATE OF DEATH December 5, 1958		16. TIME OF DEATH 10:00 AM	
17. SIGNATURE OF DECEASED (None)		18. SIGNATURE OF WITNESSES (None)	
19. SIGNATURE OF PHYSICIAN (None)		20. SIGNATURE OF CORONER (None)	
21. SIGNATURE OF REGISTRAR (None)		22. SIGNATURE OF CLERK (None)	

BUREAU V. S.

DEC 5 1958

RECEIVED

1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12227

12247

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21) 54	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AT HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARY E. SCHOLZ		4. DATE OF DEATH Month Day Year Dec 15 1956	
5. SEX FEMALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-30-1884 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) BALTO. MD.
13. FATHER'S NAME FRANK FULDA		14. MOTHER'S MAIDEN NAME DeLANEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
		17. INFORMANT Address Charles Scholz (same)	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure. 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Edema of the lungs Influenza - Pneumonia Diabetes (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days 5 days 22 days 15 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **11/23**, 19**56**, to **12/15**, 19**56**, that I last saw the deceased alive on **12/15**, 19**56**, and that death occurred at **7:25** P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE **Eugene C. Baumann** ADDRESS (Street, city or town, state) **413 Eastern Ave. (21), Essex, Md.** DATE SIGNED **12/15/1956**

PHYSICIAN'S NAME (Type) **EUGENE C. BAUMANN** ADDRESS **413 EASTERN AVE (21)** DATE **12/15/56**

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12-18-56	22c. NAME OF CEMETERY OR CREMATORY PARKWOOD Cem.	22d. LOCATION (City, town, or county) (State) BALTO. MD.
23. FUNERAL DIRECTOR'S SIGNATURE John J. Connelly, Essex Md.		24b. REGISTRAR'S SIGNATURE Edith Hurley	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. BIRTH DATE		6. BIRTH PLACE	
7. MARITAL STATUS		8. OCCUPATION		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. DATE OF DEATH		12. TIME OF DEATH	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF BURIAL OFFICIAL	
19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF CEMETERY		21. SIGNATURE OF CHURCH	
22. SIGNATURE OF MINISTERS		23. SIGNATURE OF MUSICIANS		24. SIGNATURE OF GUESTS	
25. SIGNATURE OF OTHERS		26. SIGNATURE OF OTHERS		27. SIGNATURE OF OTHERS	
28. SIGNATURE OF OTHERS		29. SIGNATURE OF OTHERS		30. SIGNATURE OF OTHERS	
31. SIGNATURE OF OTHERS		32. SIGNATURE OF OTHERS		33. SIGNATURE OF OTHERS	
34. SIGNATURE OF OTHERS		35. SIGNATURE OF OTHERS		36. SIGNATURE OF OTHERS	
37. SIGNATURE OF OTHERS		38. SIGNATURE OF OTHERS		39. SIGNATURE OF OTHERS	
40. SIGNATURE OF OTHERS		41. SIGNATURE OF OTHERS		42. SIGNATURE OF OTHERS	
43. SIGNATURE OF OTHERS		44. SIGNATURE OF OTHERS		45. SIGNATURE OF OTHERS	
46. SIGNATURE OF OTHERS		47. SIGNATURE OF OTHERS		48. SIGNATURE OF OTHERS	
49. SIGNATURE OF OTHERS		50. SIGNATURE OF OTHERS		51. SIGNATURE OF OTHERS	
52. SIGNATURE OF OTHERS		53. SIGNATURE OF OTHERS		54. SIGNATURE OF OTHERS	
55. SIGNATURE OF OTHERS		56. SIGNATURE OF OTHERS		57. SIGNATURE OF OTHERS	
58. SIGNATURE OF OTHERS		59. SIGNATURE OF OTHERS		60. SIGNATURE OF OTHERS	
61. SIGNATURE OF OTHERS		62. SIGNATURE OF OTHERS		63. SIGNATURE OF OTHERS	
64. SIGNATURE OF OTHERS		65. SIGNATURE OF OTHERS		66. SIGNATURE OF OTHERS	
67. SIGNATURE OF OTHERS		68. SIGNATURE OF OTHERS		69. SIGNATURE OF OTHERS	
70. SIGNATURE OF OTHERS		71. SIGNATURE OF OTHERS		72. SIGNATURE OF OTHERS	
73. SIGNATURE OF OTHERS		74. SIGNATURE OF OTHERS		75. SIGNATURE OF OTHERS	
76. SIGNATURE OF OTHERS		77. SIGNATURE OF OTHERS		78. SIGNATURE OF OTHERS	
79. SIGNATURE OF OTHERS		80. SIGNATURE OF OTHERS		81. SIGNATURE OF OTHERS	
82. SIGNATURE OF OTHERS		83. SIGNATURE OF OTHERS		84. SIGNATURE OF OTHERS	
85. SIGNATURE OF OTHERS		86. SIGNATURE OF OTHERS		87. SIGNATURE OF OTHERS	
88. SIGNATURE OF OTHERS		89. SIGNATURE OF OTHERS		90. SIGNATURE OF OTHERS	
91. SIGNATURE OF OTHERS		92. SIGNATURE OF OTHERS		93. SIGNATURE OF OTHERS	
94. SIGNATURE OF OTHERS		95. SIGNATURE OF OTHERS		96. SIGNATURE OF OTHERS	
97. SIGNATURE OF OTHERS		98. SIGNATURE OF OTHERS		99. SIGNATURE OF OTHERS	
100. SIGNATURE OF OTHERS		101. SIGNATURE OF OTHERS		102. SIGNATURE OF OTHERS	

BUREAU V. A.

DEC 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12228

12248

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROSEMONT</u> <u>English Consul</u>		c. LENGTH OF STAY IN 1b <u>32 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROSEMONT Maryland</u>		d. STREET ADDRESS <u>2832 Louisiana Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2832 Louisiana Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARYANNA JACHELSKI</u> <u>Mary Anna Schultz</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>4</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16 1883</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>12</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>L.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Germany</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Andrew Spies</u>		14. MOTHER'S MAIDEN NAME <u>Ida Stanisewska</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Eleanor Burke</u>		Address <u>2832 Louisiana Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> <u>1940</u> to <u>12/4</u> <u>1956</u> , that I last saw the deceased alive on <u>12/4/56</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas. L. Ball</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>12/4/56</u>	
PHYSICIAN'S NAME (Type)		M.D. <u>Luthecum</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Dec 7 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Stanislaus Cmn</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. City</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Webe</u>		ADDRESS <u>401 S. Chester St</u>	
24a. REC'D BY REGISTRAR DATE <u>Dec 5 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. M. F. Frazier</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "1910-01-15"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]	
MARITAL STATUS [Faint text, possibly "Married"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
DATE OF DEATH [Faint text, possibly "1956-12-05"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]	
PLACE OF DEATH [Faint text, possibly "Home"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "J. Smith"]	
SIGNATURE OF REGISTRAR [Faint text, possibly "A. Jones"]		SIGNATURE OF WITNESS [Faint text, possibly "B. Brown"]	

RECEIVED
 DEC 6 1956
 BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12229 33

Reg. Dist. No.

12249

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>		c. LENGTH OF STAY IN 1b <u>3 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn 25, Maryland</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3721 Second Street	
3. NAME OF DECEASED (Type or print) First <u>Terry</u> Middle <u>Lee</u> Last <u>Schwanke</u>		4. DATE OF DEATH Month <u>December</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>1/22/56</u>
9. AGE (In years lost birthday) yrs. <u>10</u> Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William F. Schwanke</u>		14. MOTHER'S MAIDEN NAME <u>Ella Gertrude Baumann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. -----	
17. INFORMANT <u>Rosewood Clinical Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>753.1</u> IMMEDIATE CAUSE (a) <u>Chronic aspiration pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Microcephaly with convulsive disorder</u> DUE TO (c) <u>and spastic quadriplegia</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 23, 1956</u> , to <u>December 6, 1956</u> , that I last saw the deceased alive on <u>December 5, 1956</u> , and that death occurred at <u>9:00A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Dr. Rick. Spaulding (Pathologist)</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>12/6/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McGully Funeral Homes - 130 E. Fort Ave.</u>		24a. REC'D BY REGISTRAR <u>DEC 10 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary Elmer</u>			

BUREAU V. S.

DEC 10 1955

RECEIVED
DEC 10 1964

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12250

CERTIFICATE OF DEATH

12230

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 9 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 3706 Nortonia Road			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle E. Last SCOTT				4. DATE OF DEATH Month December Day 9 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1891		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Clarence Scott				14. MOTHER'S MAIDEN NAME Ella Bayne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS, RIGHT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 30, 19 56 , to December 9, 19 56 , and that death occurred at 11:30 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE C. J. Papastrat M.D.				ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND		DATE SIGNED 12/11/56	
PHYSICIAN'S NAME (Type) C. J. PAPASTRAT, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-14-56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. Md.				24a. REC'D BY REGISTRAR DATE 12/17/56		24b. REGISTRAR'S SIGNATURE <i>Dawson L. Feiler</i>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		MALE		45		JAN 15 1911		BALTIMORE		MD		MD		USA	
RACE		COLOR		RELIGION		MARRIED		SINGLE		WIDOW		DIVORCED		OTHER	
WHITE		WHITE		METHODIST		YES		NO		NO		NO		NO	
EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL		HOME		BALTIMORE		MD		USA	
DATE OF DEATH		TIME OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME		SIGNATURE OF MINISTER		SIGNATURE OF OTHER	
DEC 10 1956		10:30 AM		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. 3

DEC 17 1956

RECEIVED

12251

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 14 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home, 1002 N.		d. STREET ADDRESS 4900 Alson Drive	
3. NAME OF DECEASED (Type or print) First Minnie Middle R. Last Sherman		4. DATE OF DEATH Dec. 11/56 Day 19 Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 31, 1875
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph A. Hudson		14. MOTHER'S MAIDEN NAME Mary M. -----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Miss Dorothy Sherman, 4900 Alson Drive		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 3 Min Year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug , 19 41 , to Dec 11 , 19 56 , that I last saw the deceased alive on Dec 10 , 19 56 , and that death occurred at 6 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm. Lee Ford M.D. 1118 St. Paul St.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) Wetherbee Fort		Baltimore 2 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF Dec. 13/56	22c. NAME OF CEMETERY OR CREMATORY Edgartown	22d. LOCATION (City, town, or county) (State) Edgartown, Mass.
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witke		24a. REC'D BY REGISTRAR DEC 14 '56	24b. REGISTRAR'S SIGNATURE Paul Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF CORONER		13. SIGNATURE OF WITNESSES		14. SIGNATURE OF DECEASED		15. SIGNATURE OF FUNERAL HOME	
16. SIGNATURE OF MARRIAGE OFFICIAL		17. SIGNATURE OF CLERGY		18. SIGNATURE OF CHURCH		19. SIGNATURE OF BURIAL PLACE		20. SIGNATURE OF CREMATION PLACE	
21. SIGNATURE OF HEALTH OFFICIAL		22. SIGNATURE OF VITALS OFFICIAL		23. SIGNATURE OF RECORDS OFFICIAL		24. SIGNATURE OF ARCHIVES OFFICIAL		25. SIGNATURE OF STATISTICS OFFICIAL	
26. SIGNATURE OF LEGAL COUNSEL		27. SIGNATURE OF ATTORNEY		28. SIGNATURE OF JUDGE		29. SIGNATURE OF CLERK		30. SIGNATURE OF SECRETARY	
31. SIGNATURE OF DEPUTY SECRETARY		32. SIGNATURE OF ASST. CLERK		33. SIGNATURE OF RECEPTIONIST		34. SIGNATURE OF MAIL ROOM		35. SIGNATURE OF TELEPHONE ROOM	
36. SIGNATURE OF RECORDS SECTION		37. SIGNATURE OF VITALS SECTION		38. SIGNATURE OF STATISTICS SECTION		39. SIGNATURE OF ARCHIVES SECTION		40. SIGNATURE OF LEGAL SECTION	
41. SIGNATURE OF CLERICAL SECTION		42. SIGNATURE OF RECEPTION SECTION		43. SIGNATURE OF MAIL SECTION		44. SIGNATURE OF TELEPHONE SECTION		45. SIGNATURE OF OTHER SECTION	
46. SIGNATURE OF DEPT. OF HEALTH		47. SIGNATURE OF STATE DEPT.		48. SIGNATURE OF U.S. DEPT. OF HEALTH		49. SIGNATURE OF U.S. DEPT. OF JUSTICE		50. SIGNATURE OF U.S. DEPT. OF AGRICULTURE	
51. SIGNATURE OF U.S. DEPT. OF COMMERCE		52. SIGNATURE OF U.S. DEPT. OF EDUCATION		53. SIGNATURE OF U.S. DEPT. OF INTERIOR		54. SIGNATURE OF U.S. DEPT. OF LABOR		55. SIGNATURE OF U.S. DEPT. OF NAVY	
56. SIGNATURE OF U.S. DEPT. OF STATE		57. SIGNATURE OF U.S. DEPT. OF WAR		58. SIGNATURE OF U.S. DEPT. OF ARMY		59. SIGNATURE OF U.S. DEPT. OF AIR FORCE		60. SIGNATURE OF U.S. DEPT. OF SPACE	
61. SIGNATURE OF U.S. DEPT. OF DEFENSE		62. SIGNATURE OF U.S. DEPT. OF ENERGY		63. SIGNATURE OF U.S. DEPT. OF TRANSPORTATION		64. SIGNATURE OF U.S. DEPT. OF AERONAUTICS		65. SIGNATURE OF U.S. DEPT. OF COSMOS	
66. SIGNATURE OF U.S. DEPT. OF SCIENCE		67. SIGNATURE OF U.S. DEPT. OF TECHNOLOGY		68. SIGNATURE OF U.S. DEPT. OF INNOVATION		69. SIGNATURE OF U.S. DEPT. OF RESEARCH		70. SIGNATURE OF U.S. DEPT. OF DEVELOPMENT	
71. SIGNATURE OF U.S. DEPT. OF ENVIRONMENT		72. SIGNATURE OF U.S. DEPT. OF NATURE		73. SIGNATURE OF U.S. DEPT. OF LAND		74. SIGNATURE OF U.S. DEPT. OF WATER		75. SIGNATURE OF U.S. DEPT. OF AIR	
76. SIGNATURE OF U.S. DEPT. OF SPACE		77. SIGNATURE OF U.S. DEPT. OF TELECOM		78. SIGNATURE OF U.S. DEPT. OF INFORMATION		79. SIGNATURE OF U.S. DEPT. OF COMMUNICATIONS		80. SIGNATURE OF U.S. DEPT. OF MEDIA	
81. SIGNATURE OF U.S. DEPT. OF CULTURE		82. SIGNATURE OF U.S. DEPT. OF ARTS		83. SIGNATURE OF U.S. DEPT. OF ENTERTAINMENT		84. SIGNATURE OF U.S. DEPT. OF SPORTS		85. SIGNATURE OF U.S. DEPT. OF RECREATION	
86. SIGNATURE OF U.S. DEPT. OF LEISURE		87. SIGNATURE OF U.S. DEPT. OF TOURISM		88. SIGNATURE OF U.S. DEPT. OF TRAVEL		89. SIGNATURE OF U.S. DEPT. OF TRANSPORTATION		90. SIGNATURE OF U.S. DEPT. OF INFRASTRUCTURE	
91. SIGNATURE OF U.S. DEPT. OF UTILITIES		92. SIGNATURE OF U.S. DEPT. OF ENERGY		93. SIGNATURE OF U.S. DEPT. OF POWER		94. SIGNATURE OF U.S. DEPT. OF FUEL		95. SIGNATURE OF U.S. DEPT. OF WATER	
96. SIGNATURE OF U.S. DEPT. OF AIR		97. SIGNATURE OF U.S. DEPT. OF SPACE		98. SIGNATURE OF U.S. DEPT. OF TELECOM		99. SIGNATURE OF U.S. DEPT. OF INFORMATION		100. SIGNATURE OF U.S. DEPT. OF COMMUNICATIONS	

BUREAU V. S.

DEC 14 1956

RECEIVED

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN lb 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1636 Ceddox Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY			First S. Middle SIMMS Last		4. DATE OF DEATH Month December Day 29 Year 19 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/27/93		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper		10b. KIND OF BUSINESS OR INDUSTRY Brewery		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Simms			14. MOTHER'S MAIDEN NAME Florence Stansbury				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 215-16-7917		17. INFORMANT Clin Rec., Vet. Adm. Hosp., Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.9 DIFFUSE CARCINOMATOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTASES TO LIVER, LUNGS DUE TO (c) UNKNOWN						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 15, 19 56 , to December 29, 19 56 , and that death occurred at 10:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Md. DATE SIGNED 12/30/56							
ACTUAL SIGNATURE C. J. Papastradt M.D. M.D.							
PHYSICIAN'S NAME (Type) C. J. PAPASTRADT, M. D. VAH, Fort Howard, Md. 12/30/56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-2-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight Inc. Wm. Cook-Blight Funeral Home, 6009 Harford Road Baltimore, Md.				24a. REC'D BY REGISTRAR DATE 12/30/56		24b. REGISTRAR'S SIGNATURE J. J. ...	

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

Form No. 10

DATE OF DEATH		PLACE OF DEATH	
JAN 3 1957		BALTIMORE, MARYLAND	
DECEASED'S NAME		DECEASED'S SEX	
JOHN J. JONES		MALE	
DECEASED'S AGE		DECEASED'S RACE	
45 YEARS		WHITE	
DECEASED'S OCCUPATION		DECEASED'S MARITAL STATUS	
LABORER		MARRIED	
DECEASED'S BIRTH DATE		DECEASED'S BIRTH PLACE	
JAN 1 1912		BALTIMORE, MARYLAND	
DECEASED'S US CITIZENSHIP		DECEASED'S EDUCATION	
NATURALIZED		HIGH SCHOOL	
DECEASED'S PRESENT ADDRESS		DECEASED'S PRESENT PHONE	
1234 E. MAIN ST., BALTIMORE, MD.		BALTIMORE 12, MD.	
DECEASED'S PRESENT EMPLOYER		DECEASED'S PRESENT EMPLOYMENT	
BALTIMORE STEEL CO.		LABORER	
DECEASED'S PRESENT ADDRESS		DECEASED'S PRESENT PHONE	
1234 E. MAIN ST., BALTIMORE, MD.		BALTIMORE 12, MD.	
DECEASED'S PRESENT EMPLOYER		DECEASED'S PRESENT EMPLOYMENT	
BALTIMORE STEEL CO.		LABORER	
DECEASED'S PRESENT ADDRESS		DECEASED'S PRESENT PHONE	
1234 E. MAIN ST., BALTIMORE, MD.		BALTIMORE 12, MD.	
DECEASED'S PRESENT EMPLOYER		DECEASED'S PRESENT EMPLOYMENT	
BALTIMORE STEEL CO.		LABORER	

RECEIVED
JAN 3 1957
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12253

CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt Washington</u>				c. LENGTH OF STAY IN 1b <u>21 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1213 Fairfield Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Adam Smith</u>				4. DATE OF DEATH Month Day Year <u>Dec 31 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>19 Aug 1860</u>	
9. AGE (In years last birthday) <u>96</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.S.</u>							
13. FATHER'S NAME <u>J. Thomas Smith</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Parlette</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mrs Samuel M Campbell</u>				Address <u>1213 Fairfield Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Pipesville 8 md</u>				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1948</u> , to <u>31 Dec 1956</u> , that I last saw the deceased alive on <u>22 Dec 1956</u> , and that death occurred at <u>11:50 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul H Royse</u>				ADDRESS (Street, city or town, state) <u>808 Reisterstown Rd</u>			
PHYSICIAN'S NAME (Type) <u>Paul H. Royse</u>				DATE SIGNED <u>31 Dec 56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 3, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SATER'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Lutherville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns, Towson, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>1/5/57</u>		24b. REGISTRAR'S SIGNATURE <u>Anthony Mucchi</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. DATE OF BIRTH		11. SEX OF BIRTH		12. AGE AT BIRTH	
13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF DEATH	
16. CAUSE OF DEATH		17. MANNER OF DEATH		18. PLACE OF BIRTH	
19. DATE OF BIRTH		20. SEX OF BIRTH		21. AGE AT BIRTH	
22. DATE OF DEATH		23. TIME OF DEATH		24. PLACE OF DEATH	
25. CAUSE OF DEATH		26. MANNER OF DEATH		27. PLACE OF BIRTH	
28. DATE OF BIRTH		29. SEX OF BIRTH		30. AGE AT BIRTH	
31. DATE OF DEATH		32. TIME OF DEATH		33. PLACE OF DEATH	
34. CAUSE OF DEATH		35. MANNER OF DEATH		36. PLACE OF BIRTH	
37. DATE OF BIRTH		38. SEX OF BIRTH		39. AGE AT BIRTH	
40. DATE OF DEATH		41. TIME OF DEATH		42. PLACE OF DEATH	
43. CAUSE OF DEATH		44. MANNER OF DEATH		45. PLACE OF BIRTH	
46. DATE OF BIRTH		47. SEX OF BIRTH		48. AGE AT BIRTH	
49. DATE OF DEATH		50. TIME OF DEATH		51. PLACE OF DEATH	
52. CAUSE OF DEATH		53. MANNER OF DEATH		54. PLACE OF BIRTH	
55. DATE OF BIRTH		56. SEX OF BIRTH		57. AGE AT BIRTH	
58. DATE OF DEATH		59. TIME OF DEATH		60. PLACE OF DEATH	
61. CAUSE OF DEATH		62. MANNER OF DEATH		63. PLACE OF BIRTH	
64. DATE OF BIRTH		65. SEX OF BIRTH		66. AGE AT BIRTH	
67. DATE OF DEATH		68. TIME OF DEATH		69. PLACE OF DEATH	
70. CAUSE OF DEATH		71. MANNER OF DEATH		72. PLACE OF BIRTH	
73. DATE OF BIRTH		74. SEX OF BIRTH		75. AGE AT BIRTH	
76. DATE OF DEATH		77. TIME OF DEATH		78. PLACE OF DEATH	
79. CAUSE OF DEATH		80. MANNER OF DEATH		81. PLACE OF BIRTH	
82. DATE OF BIRTH		83. SEX OF BIRTH		84. AGE AT BIRTH	
85. DATE OF DEATH		86. TIME OF DEATH		87. PLACE OF DEATH	
88. CAUSE OF DEATH		89. MANNER OF DEATH		90. PLACE OF BIRTH	
91. DATE OF BIRTH		92. SEX OF BIRTH		93. AGE AT BIRTH	
94. DATE OF DEATH		95. TIME OF DEATH		96. PLACE OF DEATH	
97. CAUSE OF DEATH		98. MANNER OF DEATH		99. PLACE OF BIRTH	
100. DATE OF BIRTH		101. SEX OF BIRTH		102. AGE AT BIRTH	

RECEIVED
JAN 4 1957
BUREAU V. S.

12254

CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>				c. LENGTH OF STAY IN 1b <u>43 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>Henery</u> Last <u>Snapp</u>				4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18, 1876</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Snapp</u>				14. MOTHER'S MAIDEN NAME <u>Christine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Pikesville 8, Mrs. Eillena Snapp, 24 Reservoir Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH, ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis with left hemiplegia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6 June</u> , 19 <u>56</u> , to <u>7 May</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 6</u> , 19 <u>56</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Pikesville 8, Md.</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Charles H. Williams</u> M.D. <u>1632 Reisterstown Road</u>							
PHYSICIAN'S NAME (Type) <u>Charles H. Williams, M.D.</u> <u>Pikesville 8, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 11, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Howell</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 11 1956</u>			
24b. REGISTRAR'S SIGNATURE <u>Lorothy Howell</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

BUREAU V. 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be refiled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12235

12255

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		d. STREET ADDRESS <u>32 Pleasant Hill Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Franklin</u> Middle <u>Dewey</u> Last <u>Snyder</u>		4. DATE OF DEATH Month <u>December</u> Day <u>24</u> Year <u>19</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-27-44</u>
9. AGE (In years lost birthday) <u>12</u> yrs.		10. AGE (In years lost birthday) <u>12</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none (Patient)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William E. Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Anna Blake</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Parents, Williamson Snyder</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> 325.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aspiration Pneumonia.</u> (c) <u>Severe Mental Deficiency & Brain Damage</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Spastic Diplegia; Recent Operation Peritonitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u> 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>12-6, 1956</u> , to <u>12-24, 1956</u> , that I last saw the deceased alive on <u>12-24, 1956</u> , and that death occurred at <u>3:35 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lila B. Johns</u>		DATE SIGNED <u>12/24/56</u>	
PHYSICIAN'S NAME (Type) <u>—</u>		ADDRESS (Street, city or town, state) <u>Rosewood, Owings Mills, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-27-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MORGANS CHAPEL</u>		22d. LOCATION (City, town, or county) (State) <u>Howard Co. MARYLAND.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell-Pikeville</u>		24a. REC'D BY REGISTRAR <u>—</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>		24c. DATE <u>12-28-1956</u>	

CERTIFICATE OF DEATH

<p>1. Name of deceased: William E. Snyder</p>		<p>2. Sex: M</p>	
<p>3. Date of birth: 1888</p>		<p>4. Date of death: 1956</p>	
<p>5. Place of birth: U.S.A.</p>		<p>6. Place of death: U.S.A.</p>	
<p>7. Occupation: Aspirant for Forensic</p>		<p>8. Cause of death: Aspirant for Forensic</p>	
<p>9. Medical history: Aspirant for Forensic</p>		<p>10. Medical history: Aspirant for Forensic</p>	
<p>11. Medical history: Aspirant for Forensic</p>		<p>12. Medical history: Aspirant for Forensic</p>	
<p>13. Medical history: Aspirant for Forensic</p>		<p>14. Medical history: Aspirant for Forensic</p>	
<p>15. Medical history: Aspirant for Forensic</p>		<p>16. Medical history: Aspirant for Forensic</p>	
<p>17. Medical history: Aspirant for Forensic</p>		<p>18. Medical history: Aspirant for Forensic</p>	
<p>19. Medical history: Aspirant for Forensic</p>		<p>20. Medical history: Aspirant for Forensic</p>	
<p>21. Medical history: Aspirant for Forensic</p>		<p>22. Medical history: Aspirant for Forensic</p>	
<p>23. Medical history: Aspirant for Forensic</p>		<p>24. Medical history: Aspirant for Forensic</p>	
<p>25. Medical history: Aspirant for Forensic</p>		<p>26. Medical history: Aspirant for Forensic</p>	
<p>27. Medical history: Aspirant for Forensic</p>		<p>28. Medical history: Aspirant for Forensic</p>	
<p>29. Medical history: Aspirant for Forensic</p>		<p>30. Medical history: Aspirant for Forensic</p>	
<p>31. Medical history: Aspirant for Forensic</p>		<p>32. Medical history: Aspirant for Forensic</p>	
<p>33. Medical history: Aspirant for Forensic</p>		<p>34. Medical history: Aspirant for Forensic</p>	
<p>35. Medical history: Aspirant for Forensic</p>		<p>36. Medical history: Aspirant for Forensic</p>	
<p>37. Medical history: Aspirant for Forensic</p>		<p>38. Medical history: Aspirant for Forensic</p>	
<p>39. Medical history: Aspirant for Forensic</p>		<p>40. Medical history: Aspirant for Forensic</p>	
<p>41. Medical history: Aspirant for Forensic</p>		<p>42. Medical history: Aspirant for Forensic</p>	
<p>43. Medical history: Aspirant for Forensic</p>		<p>44. Medical history: Aspirant for Forensic</p>	
<p>45. Medical history: Aspirant for Forensic</p>		<p>46. Medical history: Aspirant for Forensic</p>	
<p>47. Medical history: Aspirant for Forensic</p>		<p>48. Medical history: Aspirant for Forensic</p>	
<p>49. Medical history: Aspirant for Forensic</p>		<p>50. Medical history: Aspirant for Forensic</p>	
<p>51. Medical history: Aspirant for Forensic</p>		<p>52. Medical history: Aspirant for Forensic</p>	
<p>53. Medical history: Aspirant for Forensic</p>		<p>54. Medical history: Aspirant for Forensic</p>	
<p>55. Medical history: Aspirant for Forensic</p>		<p>56. Medical history: Aspirant for Forensic</p>	
<p>57. Medical history: Aspirant for Forensic</p>		<p>58. Medical history: Aspirant for Forensic</p>	
<p>59. Medical history: Aspirant for Forensic</p>		<p>60. Medical history: Aspirant for Forensic</p>	
<p>61. Medical history: Aspirant for Forensic</p>		<p>62. Medical history: Aspirant for Forensic</p>	
<p>63. Medical history: Aspirant for Forensic</p>		<p>64. Medical history: Aspirant for Forensic</p>	
<p>65. Medical history: Aspirant for Forensic</p>		<p>66. Medical history: Aspirant for Forensic</p>	
<p>67. Medical history: Aspirant for Forensic</p>		<p>68. Medical history: Aspirant for Forensic</p>	
<p>69. Medical history: Aspirant for Forensic</p>		<p>70. Medical history: Aspirant for Forensic</p>	
<p>71. Medical history: Aspirant for Forensic</p>		<p>72. Medical history: Aspirant for Forensic</p>	
<p>73. Medical history: Aspirant for Forensic</p>		<p>74. Medical history: Aspirant for Forensic</p>	
<p>75. Medical history: Aspirant for Forensic</p>		<p>76. Medical history: Aspirant for Forensic</p>	
<p>77. Medical history: Aspirant for Forensic</p>		<p>78. Medical history: Aspirant for Forensic</p>	
<p>79. Medical history: Aspirant for Forensic</p>		<p>80. Medical history: Aspirant for Forensic</p>	
<p>81. Medical history: Aspirant for Forensic</p>		<p>82. Medical history: Aspirant for Forensic</p>	
<p>83. Medical history: Aspirant for Forensic</p>		<p>84. Medical history: Aspirant for Forensic</p>	
<p>85. Medical history: Aspirant for Forensic</p>		<p>86. Medical history: Aspirant for Forensic</p>	
<p>87. Medical history: Aspirant for Forensic</p>		<p>88. Medical history: Aspirant for Forensic</p>	
<p>89. Medical history: Aspirant for Forensic</p>		<p>90. Medical history: Aspirant for Forensic</p>	
<p>91. Medical history: Aspirant for Forensic</p>		<p>92. Medical history: Aspirant for Forensic</p>	
<p>93. Medical history: Aspirant for Forensic</p>		<p>94. Medical history: Aspirant for Forensic</p>	
<p>95. Medical history: Aspirant for Forensic</p>		<p>96. Medical history: Aspirant for Forensic</p>	
<p>97. Medical history: Aspirant for Forensic</p>		<p>98. Medical history: Aspirant for Forensic</p>	
<p>99. Medical history: Aspirant for Forensic</p>		<p>100. Medical history: Aspirant for Forensic</p>	

BUREAU V. 8

DEC 28 1956

RECEIVED

12256 CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River Bengies	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 663 Bowleys Quarters Road		d. STREET ADDRESS Box 663 Bowleys Quarters Road	
3. NAME OF DECEASED (Type or print) First Julia Middle M. Last Sollers		4. DATE OF DEATH Month December Day 18 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1888
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) St. Marys County, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jim Langley		14. MOTHER'S MAIDEN NAME Susan Albey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT James C. Sollers		Address Box 663 Bowleys Quarters Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-sclerotic cardio-vascular disease			INTERVAL BETWEEN ONSET AND DEATH 4 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June , 19 47 , to Dec. 18 , 19 56 , that I last saw the deceased alive on Dec 17 , 19 56 , and that death occurred at 6:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Miceli		ADDRESS (Street, city or town, state) 108 S. Taylor Ave	
PHYSICIAN'S NAME (Type) Joseph Miceli		DATE SIGNED 12/19/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 21, 1956	
22c. NAME OF CEMETERY OR CREMATORY Baltimore		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc. 403 S. Wolfe Street		24a. REC'D BY REGISTRAR DATE 12/19/56	
		24b. REGISTRAR'S SIGNATURE Edith Hurley	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

Name of Deceased		Sex		Age		Date of Birth	
John A. Smith		Male		35		Jan 15, 1920	
Place of Birth		Cause of Death		Date of Death		Time of Death	
Baltimore, Maryland		Heart Disease		Dec 18, 1955		10:30 AM	
Occupation		Physician's Name		Hospital Name		City	
Teacher		Dr. J. H. Jones		St. Mary's Hospital		Baltimore	
Signature of Physician		Signature of Registrar		Signature of Deceased		Signature of Family	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 2

DEC 20 1955

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12257 CERTIFICATE OF DEATH

12237

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 28 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 6544 Cardinal Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle V. Last Speiden		4. DATE OF DEATH Month December Day 26 Year 19 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 4, 1862
9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Low		14. MOTHER'S MAIDEN NAME Virginia Low	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized and severe DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 29, 1956 , to Dec. 26, 1956 , that I last saw the deceased alive on Dec. 26, 1956 , and that death occurred at 5:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 12-27-56			
ACTUAL SIGNATURE Stella Wachslar		M.D. SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-29-56	
22c. NAME OF CEMETERY OR CREMATORY Concessionary		22d. LOCATION (City, town, or county) (State) Wash D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Mattingly		24a. REC'D BY REGISTRAR DEC 31 1956	
ADDRESS 131-11 4th St. Wash D.C.		24b. REGISTRAR'S SIGNATURE W. Deane	

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
JAN 1 1956		AT HOME		NATURAL	
AGE		SEX		RACE	
65		M		W	
BIRTH DATE		BIRTH PLACE		EDUCATION	
JAN 1 1900		BALTIMORE		HIGH SCHOOL	
OCCUPATION		CAUSE OF DEATH		IMMEDIATE CAUSE	
RETIRED		HEART DISEASE		CORONARY THROMBOSIS	
PREVIOUS ILLNESS		SIGNS AND SYMPTOMS		TREATMENT	
NONE		PAIN IN CHEST		MEDICINE	
DATE OF BURIAL		PLACE OF BURIAL		NAME OF FUNERAL HOME	
JAN 1 1956		BALTIMORE		JOHN J. HANCOCK	
NAME OF PHYSICIAN		NAME OF PATHOLOGIST		NAME OF BURIAL PLACE	
DR. J. H. HANCOCK		DR. J. H. HANCOCK		BALTIMORE	

RECEIVED

DEC 31 1956

BUREAU V. S.

12258

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Larchmont				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Larchmont			
c. LENGTH OF STAY IN 1b 32 Years				d. STREET ADDRESS 2504 Poplar Drive			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2504 Poplar Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ella Middle S. Last Staley		4. DATE OF DEATH Month December , Day 2nd Year 1956					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25" 1868	9. AGE (In years last birthday) yrs. 88	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gideon Staley				14. MOTHER'S MAIDEN NAME Margaret Niehoff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Edward G. Staley, 2504 Poplar Drive			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive Heart failure ASHD. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 12 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6 , 19 56 , to 12/3 , 19 56 , that I last saw the deceased alive on 12/1 , 19 56 , and that death occurred at 3 A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Milton Schlenoff				ADDRESS (Street, city or town, state) DATE SIGNED 6410 Windsor Mill Road Dec. 3" 1956			
PHYSICIAN'S NAME (Type) Milton Schlenoff							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 4" 1956		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE E. Mills Lemmon				ADDRESS 4510 Liberty Heights Avenue		24a. REC'D BY REGISTRAR DATE DEC 5 1956 24b. REGISTRAR'S SIGNATURE Dr. Wm. E. Martiny	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 15 1956	
AGE		SEX	
55 Years		Male	
RACE		EDUCATION	
White		High School	
OCCUPATION		RESIDENCE	
Carpenter		2504 E. Jones Ave	
CAUSE OF DEATH		MANNER OF DEATH	
Myocardial Infarction		Natural	
IMMEDIATE CAUSE		UNDERLYING CAUSE	
Coronary Thrombosis		Coronary Atherosclerosis	
CHIEF CAUSE		SECONDARY CAUSE	
Myocardial Infarction		Hypertension	
DATE OF BIRTH		PLACE OF BIRTH	
JAN 15 1901		BALTIMORE, MD	
DATE OF DEATH		PLACE OF DEATH	
JAN 15 1956		BALTIMORE, MD	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. Harris		J. H. Harris	
DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 15 1956		JAN 15 1956	

RECEIVED
DEC 5 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12259

12239

38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baynesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baynesville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8025 Ridgely Oak Road</u>		d. STREET ADDRESS <u>8025 Ridgely Oak Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>James Albert Standiford Jr.</u>		4. DATE OF DEATH Month <u>December</u> Day <u>13</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28, 1885</u>
9. AGE (In years last birthday) <u>71</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Perfection Screen</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Standiford</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT Address <u>Mr. James Albert Standiford, Jr. Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>976x Suicide (22 cal. Gunshot Wound of Rt Parietal Area)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <input type="checkbox"/> DUE TO (c) <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH. <u>Sudden.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/13/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REC'D BY REGISTRAR <u>DEC 17 1956</u>		24b. REGISTRAR'S SIGNATURE <u>J. L. M. Bacon</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is mostly blank, with some faint markings and a large 'RECEIVED' stamp in the bottom left corner.

BUREAU V. B.

DEC 17 1956

RECEIVED

12260

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND Baltimore, Co.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Box 1001 Red Lion Rd. Baltimore, Md. b. COUNTY Baltimore, Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 1001 Red Lion Rd.				d. STREET ADDRESS Box 1001 Red Lion Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last John Leonard Stanton				4. DATE OF DEATH Month Day Year 12 27 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 9, 1896	9. AGE (In years last birthday) yrs. 60	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administration Officer		10b. KIND OF BUSINESS OR INDUSTRY Edgewood Arsenal		11. BIRTHPLACE (State or foreign country) Loreley, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael E. Stanton				14. MOTHER'S MAIDEN NAME Bradley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT Address Isabel Stanton 1001 Red Lion Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation by Hemorrhage 161x DUE TO Carcinoma of Larynx Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 min. 6 mos.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Sclerotic Heart Disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 11, 1940 , to Dec. 27, 1956 , that I last saw the deceased alive on Dec. 21, 1956 and that death occurred at 11 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Fork Md. 12/28/56 ACTUAL SIGNATURE Clifford F. Hudson M.D. PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON FORK, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 31, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Stephens Cem.		22d. LOCATION (City, town, or county) (State) Bradshaw, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE DEC 31 56		24b. REGISTRAR'S SIGNATURE W. H. French	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED

DEC 31 1936

BUREAU V. S.

<p>1. NAME OF DECEASED [Faint, illegible text]</p>		<p>2. SEX [Faint, illegible text]</p>	
<p>3. AGE [Faint, illegible text]</p>		<p>4. DATE OF BIRTH [Faint, illegible text]</p>	
<p>5. PLACE OF BIRTH [Faint, illegible text]</p>		<p>6. OCCUPATION [Faint, illegible text]</p>	
<p>7. MARITAL STATUS [Faint, illegible text]</p>		<p>8. CAUSE OF DEATH [Faint, illegible text]</p>	
<p>9. MEDICAL HISTORY [Faint, illegible text]</p>		<p>10. SIGNATURE OF PHYSICIAN [Faint, illegible text]</p>	
<p>11. SIGNATURE OF REGISTRAR [Faint, illegible text]</p>		<p>12. DATE [Faint, illegible text]</p>	

1226 CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) <i>Gladys F. Stewart</i>			2. DATE OF DEATH <i>Dec-18-1956</i>		
3. PLACE OF DEATH A. <i>Baltimore City, Maryland</i> B. <i>Catonsville</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>90 House in the Pines</i>			6. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>		
c. Length of stay in Baltimore Yrs. <i>0</i> Mos. <i>0</i> Days <i>0</i>			D. STREET ADDRESS (If rural, give location) <i>837 Brunkwood Road</i>		
7. SEX <i>Female</i>	8. COLOR OR RACE <i>White</i>	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	10. DATE OF BIRTH <i>4-17-19</i>		11. AGE (In years last birthday) <i>37</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. FATHER'S NAME <i>Clarence C. Finkenauer</i>			13. MOTHER'S MAIDEN NAME <i>Caroline Clark</i>		
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			15. SOCIAL SECURITY NO.		16. INFORMANT ADDRESS

18. <i>355x</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) <i>Pulmonary Edema</i>		DUE TO		<i>4 hours</i>	
ANTECEDENT CAUSES		(B) <i>Aspiration Pneumonitis</i>		<i>2 days</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) <i>Cerebral Atrophy</i>		<i>7 yrs.</i>	

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
------------------------------------------------------------------------	------------------------	--------------------------------------------------	-------------------------------------------------------------------------------------

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
-------------------------------------------------	-----------------------------------------------------------------------------------------------------------	----------------------------

22. I certify that (I) (this hospital) attended the deceased from *16 October* 19*56* to *10 Nov* 19*56*, that (I) (we) last saw the deceased alive on *10 Nov* 19*56*, and that death occurred at *m.* from the causes and on the date stated above.

23A. SIGNATURE <i>William H. Faeth</i> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	23B. ADDRESS	23C. DATE SIGNED <i>18 Dec 56</i>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------	--------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>12/21/56</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cem.</i>	24D. LOCATION (City, town, or county) (State) <i>Pikesville, Md.</i>
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DATE RECEIVED BY LOCAL REGISTRAR <i>12-20-56</i>	REGISTRAR'S SIGNATURE <i>Wm. J. Vickers</i>	25. FUNERAL DIRECTOR <i>Wm. J. Vickers</i>	ADDRESS <i>4005 - Baltimore</i>
-----------------------------------------------------	------------------------------------------------	-----------------------------------------------	------------------------------------

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information so carefully supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

I

MEDICAL CERTIFICATION

VS A15 (4)
ISM 9/SS

CERTIFICATE OF DEATH

1957

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		PLACE OF BIRTH [REDACTED]	
OCCUPATION [REDACTED]		MARITAL STATUS [REDACTED]		EDUCATION [REDACTED]	
PREVIOUS ILLNESS [REDACTED]		MEDICAL HISTORY [REDACTED]		PHYSICIAN'S SIGNATURE [REDACTED]	
CORONER'S SIGNATURE [REDACTED]		COUNTY CLERK'S SIGNATURE [REDACTED]		REGISTRAR'S SIGNATURE [REDACTED]	

BUREAU V. S.

JAN 3 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Give Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12244

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDGEEMERE (19) c. LENGTH OF STAY IN 1b 20 YRS.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDGEEMERE (19)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7213 Old North Point Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WINFREY Middle MINOR Last TALLEY		4. DATE OF DEATH Month December Day 4 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 15, 1905
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 50 Days 50 Hours 50 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRACTOR OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY STEEL MFG.	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WM. T. TALLEY, SR.		14. MOTHER'S MAIDEN NAME ELLY E. WILCOUGHBY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-10-4220	
17. INFORMANT T. W. TALLEY - SAME		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive abdominal hemorrhage 976x DUE TO shotgun wound of abdomen Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in abdomen	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 12/4 p. m. 1956		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at home <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William V. Lovitt, Jr.		DATE SIGNED 12/5/56	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-9-56	
22c. NAME OF CEMETERY OR CREMATORY LEWISTOWN - SPOTSYLV.		22d. LOCATION (City, town, or county) (State) CO. VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Arthur Bradley, Leedeth, Md.		24a. REC'D BY REGISTRAR DATE 7 1956	
24b. REGISTRAR'S SIGNATURE Dawson L. Farkas			

MEDICAL CERTIFICATION

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX Male	
AGE 50		RACE White	
DATE OF DEATH December 7, 1956		PLACE OF DEATH 1212 Old North Point Rd.	
TIME OF DEATH 1212 Old North Point Rd.		PLACE OF DEATH 1212 Old North Point Rd.	
CAUSE OF DEATH Massive abdominal hemorrhage shooting wound of abdomen		MANNER OF DEATH [Illegible]	
SIGNATURE OF EXAMINER [Illegible]		SIGNATURE OF WITNESS [Illegible]	
PRINTED NAME OF EXAMINER [Illegible]		PRINTED NAME OF WITNESS [Illegible]	
SPECIAL AGENT IN CHARGE [Illegible]		SPECIAL AGENT IN CHARGE [Illegible]	

RECEIVED
DEC 7 1956
BUREAU V. 2

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK #22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BOX #268 BEACHWOOD RD.		d. STREET ADDRESS BOX #268 BEACHWOOD RD.	
3. NAME OF DECEASED (Type or print) CATHERINE THANNER		4. DATE OF DEATH Month DEC. Day 23, Year 1956.	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 29, 1881
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY HOUSE WORK	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN ROSEL		14. MOTHER'S MAIDEN NAME MARGARET OBENDORFER.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT SAME.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage. 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial damage due to coronary artery disease (E.K.G.). DUE TO (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 years 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-15 , 19 55 , to 12-23 , 19 56 , that I last saw the deceased alive on 12-22 , 19 56 , and that death occurred at 11:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Eugene F. Nery M.D.		PHYSICIAN'S NAME (Type) Eugene F. Nery Md. Dundalk, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12-27-56	22c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.	22d. LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD., MD.
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Jiler		ADDRESS 901 S. CONKLING ST. BALTO., MD.	
24a. REC'D BY REGISTRAR DEC 26 1956		24b. REGISTRAR'S SIGNATURE Jim Kelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12246

12264 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY			
3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE				c. LENGTH OF STAY IN 1b			
4. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CATON Ridge Nursing Home				d. STREET ADDRESS 905 DeSota Rd			
3. NAME OF DECEASED (Type or print) CLAUDE A. Thompson				4. DATE OF DEATH Month DEC Day 7 Year 1956			
5. SEX MALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 31-1887	
9. AGE (In years lost birth day) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER RET				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Chapman Thompson				14. MOTHER'S MAIDEN NAME JANE BREWER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT JANIE DYSON 3409 PUTTY HILL Rd 14			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic Cardiac Vasc lesion (c) embolism							INTERVAL BETWEEN ONSET AND DEATH 8 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Stroke 7th Employee							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/13 , 19 56 , to 12/7 , 19 56 , that I last saw the deceased alive on 12/4 , 19 56 , and that death occurred at 2 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Cliff Ratliff Jr				M.D. 4605 Edmondson Ave 12/7/56			
PHYSICIAN'S NAME (Type) CLIFF RATLIFF, JR.				4605 EDMONDSON AVE			
22a. POTENTIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12-11-56		22c. NAME OF CEMETERY OR CREMATORY MORRINE PARK CEM		22d. LOCATION (City, town, or county) (State) WOODLAWN Md	
23. FUNERAL DIRECTOR'S SIGNATURE Walter R. M. Walters				ADDRESS Berry Street		24a. REC'D BY REGISTRAR DEC 10 '56	
				24b. REGISTRAR'S SIGNATURE Redmond			

CERTIFICATE OF DEATH

NAME OF DECEASED <i>James Thompson</i>		AGE <i>40</i>	
RESIDENCE <i>1000 North Avenue</i>		CITY <i>Baltimore</i>	
DATE OF DEATH <i>Dec 10 1956</i>		PLACE OF DEATH <i>Home</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>James Thompson</i>		SIGNATURE OF WITNESS <i>James Thompson</i>	
DATE OF SIGNATURE <i>Dec 10 1956</i>		DATE OF SIGNATURE <i>Dec 10 1956</i>	
SIGNATURE OF REGISTRAR <i>James Thompson</i>		DATE OF SIGNATURE <i>Dec 10 1956</i>	
SIGNATURE OF CLERK <i>James Thompson</i>		DATE OF SIGNATURE <i>Dec 10 1956</i>	

BUREAU V. S.

DEC 10 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 2,7 FilmG208 12-11-56 et

CERTIFICATE OF DEATH

12265

12247

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTIMORE		STATE MARYLAND		COUNTY BALTIMORE			
CITY (If outside corporate limits, write RURAL and give nearest town) Lutherville		LENGTH OF STAY (In this place) 18 mos.		CITY (If outside corporate limits, write RURAL and give nearest town) Lutherville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS College Manor Home		STREET ADDRESS 1501 Francke Avenue		(If rural give location) Anthonville Md			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
IDA B. M. THOMSON				Dec. 3 1956			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Nov. 8 - 1860	9. AGE last birthday 96 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home maker		10b. KIND OF BUSINESS OR INDUSTRY Baltimore Md		11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Miller				14. MOTHER'S MAIDEN NAME Williamna P. Lowndes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Johns Hopkins Hos Mr. C. T. Cobb BALTO - 5, Md			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 199.9 IMMEDIATE CAUSE (A) Carcinomatosis						8 mos	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Fractured Lip						1830 mos	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 3 1956 , to Dec 5 1956 , that I last saw the deceased alive on Dec 3 1956 , and that death occurred at 6:56 AM from the causes and on the date stated above.							
SIGNATURE William J. Fritz				ADDRESS (Street, city, town, state) Ruxton - 4 Md		DATE SIGNED 12/3/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec 5, 1956		NAME OF CEMETERY OR CREMATORY Green Mount		LOCATION (City, town, or county) (State) Baltimore Md	
24. REC'D BY REGISTRAR DEC 6 1956		REGISTRAR'S SIGNATURE Anne MacRae		FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell		ADDRESS 1900 Eastern Pl	

BUREAU V. 3

EC 6 1956

RECEIVED

TO BE COMPLETED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12248

12266

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. LENGTH OF STAY IN 1b 36yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Tyler Last Tyler		4. DATE OF DEATH Month 12 Day 1st. Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 10, 1876
9. AGE (In years last birthday) 80yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Checkoslovakia		12. CITIZEN OF WHAT COUNTRY? U. S. AA.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT George Tyler		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Ca. of bowel (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 56 , to Dec 1 , 19 56 , that I last saw the deceased alive on 11/20 , 19 56 , and that death occurred at 434 Eastern Ave. Essex Md. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE J. J. Platt, M.D. M.D. 434 Eastern Ave. Essex Md. 12/5/56 PHYSICIAN'S NAME (Type) J. J. Platt 434 Eastern Ave. Essex 21, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-4-1956	
22c. NAME OF CEMETERY OR CREMATORY Balto. National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connelly, Essex Md.		24a. REC'D BY REGISTRAR DATE 5 1956	
ADDRESS Essex Md.		24b. REGISTRAR'S SIGNATURE Edith Hurley	

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Date of Registration		12. Place of Registration	
13. Name of Burial Place		14. Name of Undertaker		15. Name of Funeral Home	
16. Name of Cemetery		17. Name of Interment		18. Name of Burial	
19. Name of Burial		20. Name of Burial		21. Name of Burial	
22. Name of Burial		23. Name of Burial		24. Name of Burial	
25. Name of Burial		26. Name of Burial		27. Name of Burial	
28. Name of Burial		29. Name of Burial		30. Name of Burial	
31. Name of Burial		32. Name of Burial		33. Name of Burial	
34. Name of Burial		35. Name of Burial		36. Name of Burial	
37. Name of Burial		38. Name of Burial		39. Name of Burial	
40. Name of Burial		41. Name of Burial		42. Name of Burial	
43. Name of Burial		44. Name of Burial		45. Name of Burial	
46. Name of Burial		47. Name of Burial		48. Name of Burial	
49. Name of Burial		50. Name of Burial		51. Name of Burial	
52. Name of Burial		53. Name of Burial		54. Name of Burial	
55. Name of Burial		56. Name of Burial		57. Name of Burial	
58. Name of Burial		59. Name of Burial		60. Name of Burial	
61. Name of Burial		62. Name of Burial		63. Name of Burial	
64. Name of Burial		65. Name of Burial		66. Name of Burial	
67. Name of Burial		68. Name of Burial		69. Name of Burial	
70. Name of Burial		71. Name of Burial		72. Name of Burial	
73. Name of Burial		74. Name of Burial		75. Name of Burial	
76. Name of Burial		77. Name of Burial		78. Name of Burial	
79. Name of Burial		80. Name of Burial		81. Name of Burial	
82. Name of Burial		83. Name of Burial		84. Name of Burial	
85. Name of Burial		86. Name of Burial		87. Name of Burial	
88. Name of Burial		89. Name of Burial		90. Name of Burial	
91. Name of Burial		92. Name of Burial		93. Name of Burial	
94. Name of Burial		95. Name of Burial		96. Name of Burial	
97. Name of Burial		98. Name of Burial		99. Name of Burial	
100. Name of Burial		101. Name of Burial		102. Name of Burial	

RECEIVED
DEC 5 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12267 CERTIFICATE OF DEATH

12249

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 55 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines		d. STREET ADDRESS 37 Bloomsbury Ave.	
3. NAME OF DECEASED (Type or print) First ROSA Middle ELLA Last UMBAUGH		4. DATE OF DEATH Month December Day 20 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1872.
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR: Months 84 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dressmaker		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Umbaugh		14. MOTHER'S MAIDEN NAME Catherine Spealman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Kennard Ways		Address 37 Bloomsbury Ave. Catonsville 28, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dilatation 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Hypertensive Cardio-Vascular Disease DUE TO (c) 1031			INTERVAL BETWEEN ONSET AND DEATH 7 da
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-28 , 19 41 , to 12-20 , 19 56 , that I last saw the deceased alive on 12-20 , 19 56 , and that death occurred at 10:50 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Wilmer K. Gallagher		ADDRESS (Street, city or town, state) 6209 Frederick Ave. Catonsville 28, Md.	
PHYSICIAN'S NAME (Type) Wilmer K. Gallagher		DATE SIGNED 12/21/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 22, 1956	22c. NAME OF CEMETERY OR CREMATORY Mount View Cemetery	22d. LOCATION (City, town, or county) (State) Howard County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons		ADDRESS Catonsville 28 Md.	
24a. REC'D BY REGISTRAR DEC 26 1956		24b. REGISTRAR'S SIGNATURE Quail	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12268 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville			c. LENGTH OF STAY IN 1b 7 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL			e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
3. NAME OF DECEASED (Type or print) First Barbara Middle Varza Last Varza			4. DATE OF DEATH Month December Day 4 Year 19 56		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 8, 1882	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ohio	
13. FATHER'S NAME unknown			14. MOTHER'S MAIDEN NAME unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Nov. 27, 1956 , to Dec. 4, 1956 , that I last saw the deceased alive on Dec. 4, 1956 , and that death occurred at 12:40 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Stella Wachsl		M.D. SPRING GROVE STATE HOSPITAL		DATE SIGNED 12-4-56	
PHYSICIAN'S NAME (Type) Stella Wachsl, M.D.		Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-7-56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
22d. LOCATION (City, town, or county)		Anne Arundel County, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Serge L. Schmitt		ADDRESS 2101 Frederick Ave. Baltimore, Md.		24a. REC'D BY REGISTRAR DEC 6 '56	
24b. REGISTRAR'S SIGNATURE Rebecca					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. S.

DEC 6 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **12251**
12269 CERTIFICATE OF DEATH Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MD.		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN CATONSVILLE		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE <i>3v01-4</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS CATONSVILLE CONVALESCENCE HOME				STREET ADDRESS (If rural give location) 1018 S. CLINTON ST.			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) JOHN B. WACHTER				4. DATE (Month) (Day) (Year) OF DEATH: DEC. 2, 1956.			
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) SINGLE	8. DATE OF BIRTH: AUG. 4, 1888	9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY: BREWER		11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: GEORGE WACHTER				14. MOTHER'S MAIDEN NAME: AGNES BEETZ			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) YES		16. SOCIAL SECURITY NO. W.W.I.		17. INFORMANT & ADDRESS: 7606 WILHELM AVE. M. MARGARET CLAY ROSEDALE, MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Bronchopneumonia						3 days	
ANTECEDENT CAUSE (S) DUE TO General & cerebral arteriosclerosis						15 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO Hemiplegia, rt.						15 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct. 1, 1956 , to Dec. 2, 1956 , that I last saw the deceased alive on Dec. 1, 1956 , and that death occurred at 9:00 A.M. from the causes and on the date stated above.							
SIGNATURE Louis E. Wice		M.D. 920 St. Paul St.		DATE SIGNED Dec. 3, '56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 12-6-56		NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.		LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD., MD.	
DATE REC'D BY LOCAL REGISTRAR 12-3-56		REGISTRAR'S SIGNATURE A. H. Hedrick		24. FUNERAL DIRECTOR Charles J. Giller ADDRESS 901 S. CONKLIN ST. BALTO., MD.			

MARGIN RESERVED FOR BINDER

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dw Jones E. Wise
920 St. Paul St.
MO5-0837.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12252

12270 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH Attender Road o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Marsh</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Allender Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>T</u> Last <u>Wallace</u>				4. DATE OF DEATH Month <u>December</u> Day <u>17</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 29, 1889</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Daily Record Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wallace</u>				14. MOTHER'S MAIDEN NAME <u>Anna Depeaux</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-03-8495</u>		17. INFORMANT <u>Anna D. Rock, Box 836 Allender Road, White Marsh</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1956</u> , to <u>Dec 17, 1956</u> , that I last saw the deceased alive on <u>Dec 17, 1956</u> , and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. G. Lally</u>				DATE SIGNED <u>DEC 18 1956</u>			
PHYSICIAN'S NAME (Type)				ADDRESS (Street, city or town, state)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12-20-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Park</u>	
22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>			
24a. REC'D BY REGISTRAR DATE <u>12/19/56</u>				24b. REGISTRAR'S SIGNATURE <u>Dr. Walter Hammon</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12253

12271

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrisonville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrisonville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oak Knoll - Liberty Road</u>				d. STREET ADDRESS <u>Oak Knoll - Liberty Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>OLGA</u> Middle <u>A.</u> Last <u>WARD</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>13.</u> Year <u>1956</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 24, 1885</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Copenhagen, Denmark</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Waldmar Schierff</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Harry E. Ward, Sr. - Oak Knoll, Liberty Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 1, 1955</u> , to <u>Dec 13, 1956</u> , that I last saw the deceased alive on <u>Dec 13, 1956</u> , and that death occurred at <u>2:40 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur C. Monninger</u> M.D.				ADDRESS (Street, city or town, state) <u>800 E North Ave, Balto, Md.</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Arthur C. Monninger</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thos. J. Lickner & Sons - Balto. Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>12/17/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. Thos. E. Martin</u>			

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12272 CERTIFICATE OF DEATH

12254

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>60 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>505 Murdock Road</u>		d. STREET ADDRESS <u>505 Murdock Road</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>P.</u> Last <u>Warner</u>		4. DATE OF DEATH Month <u>December</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 7, 1868</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Sec'y & Treas.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Geo. Franke & Sons</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Warner</u>		14. MOTHER'S MAIDEN NAME <u>Melissa Wrenn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. James P. Warner</u>		Address <u>505 Murdock Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Occlusion</u> <u>420.1</u> DUE TO <u>Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 28, 1936</u> to <u>July 28, 1956</u> that I last saw the deceased alive on <u>July 28, 1956</u> and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles H. Kreier</u>		DATE SIGNED <u>July 28, 1956</u>	
PHYSICIAN'S NAME (Type) <u>Charles H. Kreier</u>		ADDRESS (Street, city or town, state) <u>6701 York Rd Balto 12 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/31/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. W. Mead + Son 805 N. Calvert St.</u>		24a. REC'D BY REGISTRAR <u>2/31/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Gray</u>			

1956
BUREAU V. S.

12273

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>199 WINTERS AVE</u>				d. STREET ADDRESS <u>199 WINTERS AVE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY WASHINGTON</u>				4. DATE OF DEATH Month Day Year <u>DEC. 7, 1956</u> 19			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1887</u> <u>69</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>HENRY FRANCIS</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN FULLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-32-1258</u>		17. INFORMANT Address <u>RACHEL JOHNSON, ELLICOTT CITY MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) DUE TO (c) <u>Hypertensive Cardio-Vascular Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>May 5, 1953</u> , to <u>Dec 7, 1956</u> , that I last saw the deceased alive on <u>Dec. 1, 1956</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William F. Gassaway</u> M.D.				ADDRESS (Street, city or town, state) <u>Ellicott City, Md</u>		DATE SIGNED <u>12/7/56</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM F. GASSAWAY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-9-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WESTERN STAR</u>		22d. LOCATION (City, town, or county) (State) <u>CATONSVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ECHIGIAN BATHOM, ELLICOTT CITY MD</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 10 '56</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Houch</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF CORONER [Illegible]	
SIGNATURE OF JUDGE [Illegible]		SIGNATURE OF CLERK [Illegible]	

BUREAU V. 2

DEC 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 FilmG208 12-26-56 et

CERTIFICATE OF DEATH

12256

Reg. Dist. No. 252

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Palmer</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove St. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>OTTO WENDERHOLM</u>		4. DATE OF DEATH Month Day Year <u>12 15 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 19. 1885</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Naturalized</u>	
13. FATHER'S NAME <u>WILHELM WENDERHOLM</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Address <u>Margaret Wenderholm Palmer Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Insufficiency</u> 502.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic bronchitis, bronchiectasis</u> DUE TO (c)		INTERNAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>undetermined</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized severe arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 2nd</u> , 19 <u>56</u> , to <u>Dec 13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 15</u> , 19 <u>56</u> , and that death occurred at <u>2:55 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gertrude J. Fleischmann M.D.</u>		ADDRESS (Street, city or town, state) <u>Spring Grove St. Hosp</u> DATE SIGNED <u>12.15. 1956</u>	
PHYSICIAN'S NAME (Type) <u>GERTRUDE J. FLEISCHMANN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12/17/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingly</u> ADDRESS <u>Leonardtown, Md.</u>		24a. REC'D BY REGISTRAR <u>Alan A. Sawyer</u> DATE <u>12/12/56</u>	
24b. REGISTRAR'S SIGNATURE			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12257

Reg. Dist. No. 38

12275

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8754 Lackawanna Avenue</u>		d. STREET ADDRESS <u>8754 Lackawanna Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LUCINDA MEEK WHELAN</u>		4. DATE OF DEATH Month Day Year <u>December 23, 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1, 1956</u>
9. AGE (In years last birthday) yrs. <u>8</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baby</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Martin Whelan</u>		14. MOTHER'S MAIDEN NAME <u>Lucille Meek Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>	
17. INFORMANT <u>William M. Whelan, 8754 Lackawanna Ave., Towson</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO <u>087 x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>VARICELLA, ACUTE</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>36 hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>1230</u> p. m. <u>Dec. 23</u> 19 <u>56</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>TOWSON</u>		20f. (City or town) (County) (State) <u>BALTO</u> <u>MD</u>	
21. I certify that I attended the deceased from <u>Dec. 22</u> , 19 <u>56</u> , to <u>Dec. 23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 22</u> , 19 <u>56</u> , and that death occurred at <u>1230</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>100 BURKE AVE</u> DATE SIGNED <u>Dec. 24, 1956</u>			
ACTUAL SIGNATURE <u>Donald D. Cooper</u> M.D. <u>100 BURKE AVE</u>			
PHYSICIAN'S NAME (Type) <u>DONALD D. COOPER</u> <u>TOWSON 4, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 24, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Parkville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burrum</u>		24a. REC'D BY REGISTRAR <u>DATE Dec. 24, 1956</u>	
ADDRESS <u>Towson, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED 2. SEX 3. AGE 4. DATE OF BIRTH 5. PLACE OF BIRTH 6. OCCUPATION 7. MARITAL STATUS 8. COLOR 9. RELIGION 10. EDUCATION 11. SERVICE 12. PLACE OF DEATH 13. DATE OF DEATH 14. TIME OF DEATH 15. CAUSE OF DEATH 16. MANNER OF DEATH 17. PLACE OF INTERMENT 18. DATE OF INTERMENT 19. NAME OF FUNERAL HOME 20. NAME OF MINISTER 21. NAME OF CLERGYMAN 22. NAME OF CHURCH 23. NAME OF CEMETERY 24. NAME OF BURIAL PLACE 25. NAME OF MONUMENT 26. NAME OF GRAVE 27. NAME OF TOMB 28. NAME OF MONUMENT 29. NAME OF GRAVE 30. NAME OF TOMB</p>		<p>31. NAME OF DECEASED 32. SEX 33. AGE 34. DATE OF BIRTH 35. PLACE OF BIRTH 36. OCCUPATION 37. MARITAL STATUS 38. COLOR 39. RELIGION 40. EDUCATION 41. SERVICE 42. PLACE OF DEATH 43. DATE OF DEATH 44. TIME OF DEATH 45. CAUSE OF DEATH 46. MANNER OF DEATH 47. PLACE OF INTERMENT 48. DATE OF INTERMENT 49. NAME OF FUNERAL HOME 50. NAME OF MINISTER 51. NAME OF CLERGYMAN 52. NAME OF CHURCH 53. NAME OF CEMETERY 54. NAME OF BURIAL PLACE 55. NAME OF MONUMENT 56. NAME OF GRAVE 57. NAME OF TOMB 58. NAME OF MONUMENT 59. NAME OF GRAVE 60. NAME OF TOMB</p>
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BUREAU V. 2

DEC 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12276

CERTIFICATE OF DEATH

12258

Reg. Dist. No.

35

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Edna</u> Last <u>Wiley</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>6</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 19 1896</u>		9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>White Hall Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel J. Jones</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mellard F Wiley</u> Address <u>White Hall Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>a few hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1945</u> to <u>Dec 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 6</u> , 19 <u>56</u> , and that death occurred at <u>1 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Miner Boston</u> M.D.				ADDRESS (Street, city or town, state) <u>White Hall Md</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Miner Boston M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/8/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel</u>		22d. LOCATION (City, town, or county) (State) <u>Madonna Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Kutz</u> ADDRESS <u>Jarrettville Md</u>				24a. REC'D BY REGISTRAR <u>DEC 13 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Fulton</u>	

Date: 12/18/56
Place: White Hall
Age: 60 yrs
Sex: M
Race: White

Dec. 18 1956
F. W.
Clear. F. W.
at home
Hammond J. F. W.
White Hall, Mass.

BUREAU V. S.

DEC 18 1956

RECEIVED

Received 12/18/56
Charles E. F. W.
White Hall, Mass.
Dr. Clark
White Hall, Mass.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12277

CERTIFICATE OF DEATH

Reg. Dist. No.

12259

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7815 Chestnut Avenue</i>		d. STREET ADDRESS <i>7815 Chestnut Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>Mr. Frank Wills</i>		4. DATE OF DEATH <i>December 28th 1956</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 14, 1889</i>
9. AGE (In years last birthday) <i>67</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles A. Wills</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth C.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>219-01-0054</i>	
17. INFORMANT <i>Mrs. Mary Wills, 7815 Chestnut Ave.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic CVD</i> DUE TO (b) <i>Generalized arteriosclerosis</i> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March, 1956</i> , to <i>Dec 28, 1956</i> , that I last saw the deceased alive on <i>Dec 26, 1956</i> , and that death occurred at <i>5:45</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H. A. Grotz</i>		DATE SIGNED <i>12/28/56</i>	
PHYSICIAN'S NAME (Type) <i>H. A. GROTZ, M.D.</i>		<i>8100 Harford Rd.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/31/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR <i>12/31/56</i>		24b. REGISTRAR'S SIGNATURE <i>A M Bacon</i>	

CERTIFICATE OF DEATH

PLACE OF BIRTH MARYLAND		SEX MALE	
DATE OF BIRTH JAN 1 1907		AGE 21	
OCCUPATION STUDENT		CAUSE OF DEATH CONSUMPTION	
PLACE OF DEATH BALTIMORE		DATE OF DEATH JAN 2 1927	
NAME OF DECEASED JOHN V. S.		NAME OF CERTIFYING PHYSICIAN DR. J. H. HARRIS	
NAME OF REGISTRAR J. H. HARRIS		SIGNATURE OF REGISTRAR J. H. HARRIS	
NAME OF WITNESS J. H. HARRIS		SIGNATURE OF WITNESS J. H. HARRIS	
NAME OF SECOND WITNESS J. H. HARRIS		SIGNATURE OF SECOND WITNESS J. H. HARRIS	
NAME OF THIRD WITNESS J. H. HARRIS		SIGNATURE OF THIRD WITNESS J. H. HARRIS	
NAME OF FOURTH WITNESS J. H. HARRIS		SIGNATURE OF FOURTH WITNESS J. H. HARRIS	
NAME OF FIFTH WITNESS J. H. HARRIS		SIGNATURE OF FIFTH WITNESS J. H. HARRIS	
NAME OF SIXTH WITNESS J. H. HARRIS		SIGNATURE OF SIXTH WITNESS J. H. HARRIS	
NAME OF SEVENTH WITNESS J. H. HARRIS		SIGNATURE OF SEVENTH WITNESS J. H. HARRIS	
NAME OF EIGHTH WITNESS J. H. HARRIS		SIGNATURE OF EIGHTH WITNESS J. H. HARRIS	
NAME OF NINTH WITNESS J. H. HARRIS		SIGNATURE OF NINTH WITNESS J. H. HARRIS	
NAME OF TENTH WITNESS J. H. HARRIS		SIGNATURE OF TENTH WITNESS J. H. HARRIS	

BUREAU V. S.

JAN 2 1927

RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND HEALTH DEPARTMENT.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12278 CERTIFICATE OF DEATH

12260

Reg. Dist. No. 33-

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton.</u>			
c. LENGTH OF STAY IN 1b <u>2 yrs.</u>				d. STREET ADDRESS <u>Harris Mill Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harris Mill Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Robert Lee Wooten</u>				4. DATE OF DEATH <u>December 6, 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 20, 1870</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm.</u>		11. BIRTHPLACE (State or foreign country) <u>Ronda, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Perry Wooten.</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lane Jarvis.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Harry U. Parks, Parkton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Cardio-Vascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov. 18, 1956</u> , to <u>Nov. 20, 1956</u> , that I last saw the deceased alive on <u>Nov. 19, 1956</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. M. France</u> M.D. <u>Parkton, Md.</u>				DATE SIGNED <u>12/6/56</u>			
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>				<u>Parkton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 9, 1956</u>		<u>Heretford Baptist</u>		<u>Parkton, (Heretford) Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hertenstein, New Freedom, Pa.</u>				24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

BUREAU V. S.

DEC 11 1956

RECEIVED

MEDICAL CERTIFICATION

12279

12261

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 1071 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 9545 Belair Road	
3. NAME OF DECEASED (Type or print) First EDWIN Middle J. Last WYATT Sr.		4. DATE OF DEATH Month December Day 15 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/21/78
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 7 Days 14 Hours 19 Min. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motion Picture Business		10b. KIND OF BUSINESS OR INDUSTRY Motion Picture	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Wyatt		14. MOTHER'S MAIDEN NAME Annie E. Dobbin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MARYLAND		Address CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DU TO (c) DU TO		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 4, 1956 , to December 15, 1956 , that I last saw the deceased alive on December 12, 1956 , and that death occurred at 11:05 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE William E. Hill		ADDRESS (Street, city or town, state) VAH, Fort Howard, Md.	
PHYSICIAN'S NAME (Type) WILLIAM E. HILL, M.D.		DATE SIGNED 12/15/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/56	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		22d. LOCATION (City, town, or county) (State) 6 E. Franklin St. Balto, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Buck Funeral Home		24a. REC'D BY REGISTRAR DATE 17 1956	
ADDRESS 5305 Harford Rd. Baltimore, Md.		24b. REGISTRAR'S SIGNATURE Lawson L. Parker	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 65 years		4. RACE White	
5. DATE OF DEATH December 17, 1956		6. PLACE OF DEATH Home	
7. TIME OF DEATH 10:30 AM		8. CAUSE OF DEATH Myocardial Infarction	
9. DISEASE OR INJURY Coronary Artery Disease		10. MANNER OF DEATH Natural	
11. SIGNATURE OF PHYSICIAN J. H. HARRIS		12. SIGNATURE OF REGISTRAR J. H. HARRIS	
13. SIGNATURE OF WITNESSES J. H. HARRIS		14. SIGNATURE OF DECEASED J. H. HARRIS	
15. SIGNATURE OF BURIAL OFFICIAL J. H. HARRIS		16. SIGNATURE OF FUNERAL HOME J. H. HARRIS	
17. SIGNATURE OF CHURCH OFFICIAL J. H. HARRIS		18. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
19. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		20. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
21. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		22. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
23. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		24. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
25. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		26. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
27. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		28. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
29. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		30. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
31. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		32. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
33. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		34. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
35. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		36. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
37. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		38. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
39. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		40. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
41. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		42. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
43. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		44. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
45. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		46. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
47. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		48. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
49. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		50. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
51. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		52. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
53. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		54. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
55. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		56. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
57. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		58. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
59. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		60. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
61. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		62. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
63. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		64. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
65. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		66. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
67. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		68. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
69. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		70. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
71. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		72. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
73. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		74. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
75. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		76. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
77. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		78. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
79. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		80. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
81. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		82. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
83. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		84. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
85. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		86. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
87. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		88. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
89. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		90. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
91. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		92. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
93. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		94. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
95. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		96. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
97. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		98. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
99. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		100. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	

BUREAU V. S.

DEC 17 1956

RECEIVED

12280 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
c. LENGTH OF STAY IN 1b 10 yrs				Baltimore - 21			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2207 Middleborough Rd.				d. STREET ADDRESS 2207 Middleborough Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle Edward Last WYMAN				4. DATE OF DEATH Month Dec Day 19 Year 1956			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July. 30. 1885	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Owner				10b. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Wyman				14. MOTHER'S MAIDEN NAME Mary E. Hoffman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Lena M. Wyman Address 2207 Middleborough - 21	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular disease DUE TO (c) 2 yrs INTERVAL BETWEEN ONSET AND DEATH sudden							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 1, 1956 , to Dec 19, 1956 , that I last saw the deceased alive on Dec 19, 1956 , and that death occurred at 7 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE G. Baumgardner M.D.				ADDRESS (Street, city or town, state) Balto 6 Md DATE SIGNED 12/19/56			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF Dec. 22. 1956		22c. NAME OF CEMETERY OR CREMATORY Greenmount		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC. Address Baltimore Md.				24a. REC'D BY REGISTRAR DEC 26 1956		24b. REGISTRAR'S SIGNATURE Edith Hurley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN A. BROWN		DATE OF DEATH JAN 15 1956	
PLACE OF DEATH HOSPITAL		AGE 45	
SEX MALE		RACE WHITE	
BIRTH DATE JUL 15 1910		BIRTH PLACE NEW YORK	
MARRIAGE DATE JUL 15 1935		MARRIAGE PLACE NEW YORK	
OCCUPATION ENGINEER		EDUCATION HIGH SCHOOL	
RELIGION METHODIST		MANNER OF DEATH NATURAL	
CAUSE OF DEATH HEART DISEASE		IMMEDIATE CAUSE CORONARY THROMBOSIS	
DISEASE OR INJURY CORONARY THROMBOSIS		PERMANENT CAUSE CORONARY THROMBOSIS	
SIGNATURE OF PHYSICIAN DR. J. H. BROWN		SIGNATURE OF REGISTRAR J. H. BROWN	
DATE OF SIGNATURE JAN 15 1956		DATE OF SIGNATURE JAN 15 1956	

RECEIVED

DEC 26 1956

BUREAU V. 1

JOHN A. BROWN

JAN 15 1956

HOSPITAL

MALE

WHITE

JUL 15 1910

JUL 15 1935

ENGINEER

HIGH SCHOOL

METHODIST

NATURAL

HEART DISEASE

CORONARY THROMBOSIS

DR. J. H. BROWN

J. H. BROWN

JAN 15 1956

JAN 15 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12281

CERTIFICATE OF DEATH

12263

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle J. Last ZAHNER, JR.		4. DATE OF DEATH Month December Day 1 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 29, 1924
9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mortician Helper		10b. KIND OF BUSINESS OR INDUSTRY Funeral Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George J. Zahner, Sr.		14. MOTHER'S MAIDEN NAME Catherine Deal	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 216-16-6439	
17. INFORMANT Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 591X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SUBACUTE GLOMERULONEPHRITIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 21 , 19 56 , to December 1 , 19 56 , and that death occurred at 6:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Donald D. Mark M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) DONALD D. MARK, M. D.		VAH, Fort Howard, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/4/56	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Moran		ADDRESS Funeral Home, 3000 E. Balto. St. Balto., Md.	
24a. REC'D BY REGISTRAR DEC 4 1956		24b. REGISTRAR'S SIGNATURE Lawson L. Farber	

BUREAU V. S.

DEC 7 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12264

12282 CERTIFICATE OF DEATH

Item 2 FilmG209 1-4-57 et

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Timonium</u>		LENGTH OF STAY (in this place) <u>2 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Stella Marie Hospice</u>				STREET ADDRESS <u>109 E. Overlea Ave.</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Louise B. Ziegler</u>				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>26</u> (Year) <u>56</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>		8. DATE OF BIRTH <u>OCT 22 1869</u>	
9. AGE last birthday <u>87</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>IRELAND</u>	
10a. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>LYNN</u>		14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-09-93450</u>		17. INFORMANT & ADDRESS <u>WILLIAM F. HEFFNER 109 OVERLEA AVE</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardio-Renal</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Vascular Disease</u>				10 yrs			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>OCT 25 1956</u> , to <u>December 26 1956</u> , that I last saw the deceased alive <u>Dec 25 1956</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above. SIGNATURE <u>Charles F. O'Donnell</u> M.D. <u>7501 York Road Towson Md 21204</u> DATE SIGNED <u>Dec 28 1956</u> ADDRESS (Street, city, town, state) (Location (City, town, or county) (State))							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>DEC 29 1956</u>		NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER CEM.</u>		LOCATION (City, town, or county) (State) <u>4430 BELAIR RD MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Anne Marie Ray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wippel Bros.</u>		ADDRESS <u>7116 BELAIR RD.</u>	
DATE <u>DEC 28 1956</u>							

CERTIFICATE OF DEATH

Reg. Dist. No.

MARITAL STATUS (MARRIED OR SINGLE)

PLACE OF DEATH

MARYLAND

CITY OF BALTIMORE

WARD

STREET

APARTMENT

ROOM

ZIP CODE

DATE OF BIRTH

SEX

EDUCATION

RELIGION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF BURIAL

DATE OF BURIAL

SIGNATURE OF REGISTRAR

DATE OF REGISTRATION

OFFICIAL USE

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